Government of Sierra Leone
Ministry of Health and Sanitation
Health Education Division

NATIONAL HEALTH PROMOTION STRATEGY OF SIERRA LEONE

(2017–2021)

2016

TABLE OF CONTENTS

ACRONYMS

ACT	Artemisinin-based Combination Therapy
ANC	Antenatal Care
BBC	British Broadcasting Corporation
BMI	Body Mass Index
BPEHS	Basic Package of Essential Health Services
C4D	Communication for Development
CCP	Johns Hopkins Center for Communication Programs
CDC	United States Centers for Disease Control and Prevention
CHW	Community Health Worker
CMO	Chief Medical Officer
CSO	Civil Society Organizations
DHMT	District Health Management Team
DHS	Demographic and Health Surveys
DPHC	Directorate of Primary Health Care
DPPI	Directorate of Policy, Planning and Information
Ebola	Ebola Virus Disease
EOC	Emergency Operations Centre
EPI	Expanded Programme on Immunization
FGM	Female Genital Mutilation
FHCI	Free Health Care Initiative
FMC	Facility Management Committee
HC3	Health Communication Capacity Collaborative
HED	Health Education Division
HMC	Health Management Committee
IEC	Information, Education and Communication
IMAM	Integrated Management of Acute Malnutrition
IPTp	Intermittent Preventive Treatment in Pregnancy
ITN	Insecticide-treated Bed Net
KAP	Knowledge, Attitudes and Practice
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MIS	Malaria Indicator Survey
MIYCN	Maternal Infant and Young Child Nutrition
MOFED	Minister of Finance and Economic Development
MOHS	Ministry of Health and Sanitation
NACP	National HIV/AIDS Control Programme
NCD	Non-communicable Disease
NGO	Non-governmental Organization
NMCP	National Malaria Control Programme
ORS	Oral Rehydration Salt
PHNEOC	Public Health National Emergency Operations Centre
PHU	Peripheral Health Units
PNC	Postnatal Care
SBCC	Social and Behaviour Change Communication
SLA	Service-level Agreement

SM	Social Mobilization
SMS	Short Message Service
SMAC	Social Mobilization and Advocacy Consortium
SO	Sub-objective
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
VSO	Voluntary Services Overseas
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

FOREWORD

In 2010, the Ministry of Health and Sanitation's Health Education Division (HED) with the World Health Organization (WHO) developed the *Health Promotion Policy*, with seven objectives. In 2012, the HED and WHO embarked on the operationalization of the Health Promotion Policy and drafted a national strategy; however, during the development of that strategy, the country was hit by the Ebola Virus Disease ("Ebola") outbreak and a state of emergency was declared in 2014. Consequently, the strategy was put on hold, and the landscape under which the HED was operating changed drastically.

Since that time, new structures for health promotion have been constituted around the emergency Ebola response, including the Social Mobilization Pillar and the Communications Pillar within the newly created Emergency Operations Centre. The Government of Sierra Leone and its partners learned many lessons during the fight against the Ebola outbreak. One of the key lessons learned was the role of community structures in promoting and ensuring health. Consequently, the national *Health Sector Recovery Plan (2015–2020),* the blueprint for rebuilding the health sector, included community ownership as one of its key strategic priorities. In addition, a Community Health Worker (CHW) Hub was created and staffed in 2016 with a clear responsibility of overseeing the nearly 15,000 CHWs who will deliver integrated health information at the community level.

This*National Health Promotion Strategy (2017 – 2021)* is timely as it will provide a framework for both community engagement and the work of the CHWs at the community level. This Strategy is designed to support the policy objectives outlined in the original policy document. While theStrategy aims to pick up where we left off before the Ebola outbreak, it also considers and incorporates lessons learned during the fight against Ebola. It outlines a plan for strengthening the HED to take health promotion in the country to the next level, and aims to harmonize health promotion efforts across the country to ensure synergy.

This Strategy contributes directly to the fulfilment of His Excellency's Delivery Priorities for the health sector, and the Ministry has been fortunate to receive significant support from our donor partners to implement social mobilization and community-level interventions, especially focusing on hard-to-reach communities. I urge all partners to recognize the critical importance of this Strategy and work to ensure the activities are implemented, as we embark on a journey to drastically reduce maternal and child mortality and improve health outcomes.

Honourable Dr Abu Bakarr Fofanah
Minister of Health and Sanitation

Freetown, Sierra Leone
December 23, 2016

ACKNOWLEDGEMENTS

The 2014-2015 Ebola Virus Disease ("Ebola") outbreak in Sierra Leone has highlighted the need for high-quality health promotion and adequate investment in this critical area. We acknowledge the significant role health promotion played in finally containing the outbreak, particularly through social mobilization and mass media communication strategies. Strategic health promotion interventions continue to promote optimal health behaviours including creating demand and increasing health service uptake. The human resource challenges that the health system faces (in terms of staff numbers and skills) extend to health promotion cadres. As a result, we face challenges of adequately addressing the health needs of the population.

The *National Health Promotion Strategy (2017-2021)* will raise the bar for higher quality health promotion across the country, addressing the operational and programmatic needs within the Ministry of Health and Sanitation (MOHS). Its guidance will support and strengthen the national *Health Sector Recovery Plan (2015-2020),* particularly the community ownership pillar of the investment framework.

The Ministry would like to thank the United States Agency for International Development (USAID) funded Health Communication Capacity Collaborative (HC3), a programme of the Johns Hopkins Center for Communication Programs (CCP),and the MOHS Health Education Division (HED) for their invaluable contribution and leadership in the formulation of this Strategy.

We would also like to thank all the stakeholders who participated in the Strategy consultations, including (but not limited to)government agencies (the MOHS Directorate of Food and Nutrition; Directorate of Reproductive and Child Health; Directorate of Planning, Policy and Information; Directorate of Disease Prevention and Control; Child Health/Expanded Programme on Immunization [EPI] programme; National Malaria Control Programme; and the Ministry of Agriculture, Forestry and Food Security) and health development partners(the World Health Organization [WHO]; United Nations International Children's Emergency Fund [UNICEF]; United Nations Population Fund [UNFPA]; John Snow Inc. [JSI]; National Secretariat for the Reduction of Teenage Pregnancy; Focus 1000; Planned Parenthood Sierra Leone; Christian Aid Sierra Leone; Child Fund; Red Cross; Marie Stopes Sierra Leone; GOAL Sierra Leone; Search for Common Ground; Action Contre La Faim [ACF]; British Broadcasting Corporation [BBC] Media Action and others).

This Strategy consists of national health priorities that all partners must rally around, including a plan for improved human resources for health promotion, capacity strengthening, advocacy and strengthened monitoring and evaluation systems. The work plan that accompanies this Strategy provides a solid roadmap, in the medium term, to improved health promotion that benefits the people of Sierra Leone. I look forward to working with all of you as we collectively implement the interventions outlined in the Strategy commencing 2017 and beyond.

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Dr. Brima Kargbo, Chief Medical Officer
Ministry of Health and Sanitation
December 23, 2016

EXECUTIVE SUMMARY

The Sierra Leone Ministry of Health and Sanitation (MOHS) *National Health Promotion Strategy (2017–2021)* is both ambitious and practical. It is ambitious in that it seeks to re-conceptualize the role of health promotion in the health sector; places families and communities at the centre of planning and action; elevates the practice of health promotion; and focuses the action of a coalition of agencies. It is practical in that it establishes the building blocks of enhanced health promotion capacity; clarifies roles and responsibilities; builds on previous policy and is built on national and international best practices; and makes difficult choices regarding priorities.

This Strategy is built on a solid foundation of policy and programme guidance. The 2000 Health Education Policy and the 2010 National Health Promotion Policy placed health promotion firmly on the national agenda. Between the launching of the latest national policy document in 2010 and the development of this Strategy, significant accomplishments have been achieved:

- The Ebola Virus Disease ("Ebola") outbreak response in 2014-2015 demonstrated the power of social mobilization (SM) and communication
- National-level coordinating committees exist
- In-service training is conducted
- Partnerships for health promotion are expanding
- District-level coordinators have been appointed in some areas
- Campaigns are happening
- Media are being used
- Tobacco control legislation is in progress

Despite these advances, much remains to be done.

Audience for this Strategy

- The **primary audience** for the Strategy is policymakers within the public health sector.
- The **secondary audiences** for the Strategy are the public, non-governmental and voluntary sector partners of the MOHS.

Organization of the Document

The National Health Promotion Strategy (2017–2021) includes these major sections:

Background:

- **Background** – Provides information on the health promotion consultation process and findings that led to the development of the Strategy
- **Situation Analysis** – Reviews essential background information that provides a context for the Strategy

Strategy:

- **Objective 1. Strengthen Health Promotion Structures**– The priorities towards this objective are to rejuvenate the SM and communications pillars; strengthen coordination mechanisms

between national- and district-level partners; strengthen the coordination, technical and leadership capacity of district-level health promotion and related structures; clarify the roles and responsibilities of community-level actors; define accountability mechanisms for addressing community concerns and strengthen, rejuvenate and reinvigorate community groups; and foster community ownership of health.

- **Objective 2.Strengthen National Health Promotion Interventions**– The priorities towards this objective are to disseminate and provide guidelines on the use of health promotion models; support national integrated efforts to reach adolescents with health promotion; establish and strengthen key change agents; strengthen health promotion interventions; ensure an evidence base for determining key behavioural determinants and communication channels in programming; prioritize health promotion needs across the MOHS unit; develop and launch a national campaign; develop and implement an emergency communication plan; and strengthen the integration of health promotion activities with activities in other sectors.

- **Objective 3. Improve Human Resources and Capacity Strengthening for Health Promotion**– The priorities towards this objective are to develop a training programme for pre-service and in-service health promotion professionals and to clarify workforce policy regarding health promotion.

- **Objective 4. Raise Awareness and Mobilize Resources for Strengthened Health Promotion**– The priorities towards this objective are to advocate for increased resources to support health promotion human resources, operational needs and activities, and to recruit private sector partners to protect families and communities.

- **Objective 5. Improve Monitoring and Evaluation Systems for Health Promotion**– The priorities towards this objective are to strengthen health promotion indicators and develop a monitoring system to report against those indicators; to create an monitoring and evaluation (M&E) subcommittee within the SM Pillar; to develop a framework for programme partners on health promotion M&E; and to implement key methodologies on a national level, including representative quantitative surveys.

- **Objective 6. Strengthen Knowledge Sharing and Management**– The priorities towards this objective include the development of a national health promotion knowledge management plan; a national health promotion library of data, resources and best practices; and a national health promotion community of practice.

Appendices:

- **Appendix A. Additional Health Landscape in Sierra Leone**–Additional information on the health landscape in Sierra Leone, as indicated in the *Situation Analysis* section.

  Appendix B. Review of National Policy and Guidance–A brief summary of the key points made in the 2010 Policy and the participants' observations.

- **Appendix C. Prioritized Health Promotion Needs Across MOHS Units**–Strategic priorities for health promotion for 2017-2021, a number of MOHS directorates and programmes identified during consultations.

- **Appendix D. Budget for the National Health Promotion Strategy (2017-2021)**
- **Appendix E. Budget Notes for National Health Promotion Strategy (2017-2021)**
- **Appendix F. National Health Promotion Strategy (2017-2021) Implementation Plan**
- **Appendix G.– M&E Indicators for National Health Promotion Strategy (2017-2021)**

Investment in this Strategy is urgently required. The lives, health and wellbeing of our citizens quite literally depend on the robust health promotion system it describes. Without it, devastation, such as the Ebola outbreak, will remain a constant threat. The global experience demonstrates that when high quality health promotion is sustained, improved health outcomes result. Both government decision-makers and our national and international partners have a role to play in this Strategy's success.

BACKGROUND

This Strategy was developed through a participatory process involving partners both within the MOHS and partners in the field who are implementing health promotion[1] activities on the ground. In May 2016, the Health Education Division (HED) partnered with the Health Communication Capacity Collaborative (HC3) programme of Johns Hopkins Center for Communication Programs (CCP) to lead a consultative process towards the goal of identifying health promotion priorities in the country.

The consultations, and the three-day workshop that followed, included approximately 30 partners: five MOHS directorates and several health programmes; the Ministry of Agriculture, Forestry and Food Security; United Nations (UN) agencies, including the United Nations International Children's Emergency Fund (UNICEF) and the World Health Organization (WHO); the United States Centers for Disease Control and Prevention (CDC) and more than 13 implementing partners.

During this process, five objectives were examined:

- Improve the coordination and quality of health promotion
- Identify areas for common action among several health promotion partners
- Improve and expand human resources available for health promotion
- Increase the profile of and resources for health promotion
- Develop a health promotion monitoring and evaluation (M&E)system

While key outcomes from the consultations and workshop are incorporated throughout the Strategy, more detailed information is included below.

Adolescents as Key Audiences

Government officials and partners alike agreed that the national Strategy should choose a key audience of focus. The rationale for choosing a priority audience was that there will be greater impact if more than one agency focuses on one key audience. During consultations, a broad cross section of public sector and non-governmental organization (NGO) agencies selected older adolescents (ages 15 to 19) followed by younger adolescents (ages 12 to 14) as the key primary audience, noting that 34 percent of all pregnancies occur among teens and 40 percent of maternal deaths are due to teenage pregnancies.

It was agreed that, in order to reach the key audiences, the primary influencing audiences would need to be considered as well. Consultation participants considered the relative importance of reaching eight different audiences: traditional leaders, religious leaders, younger adolescents, older adolescents, emerging adults (ages 20 to 24), adults (ages 25 to 36), older adults (age 37 and older) and men. It is important to highlight that, among young people in Sierra Leone, eight percent of pregnancies were conceived with a member of their peer/same age group, while 35 percent of adolescent girls and young women were impregnated by men more than 10 years older (Demographic and Health Surveys [DHS], 2008). Participants considered several factors, including the impact on reducing maternal, newborn and child mortality; the willingness of the audience to adopt new behaviours (openness to change); national population representation; vulnerability to health outcomes; and whether the segment is under-served and lacks decision-making power.

[1] Referred to in some instances as "HP"

The value of choosing this priority audience is clear: real change can be made in Sierra Leone if agencies rally around the cause of providing these young people with the information and motivation they need to start their lives in a healthy manner. See *Objective 2. Strengthen National Health Promotion Interventions* for more information.

Key Community Change Agents

Another priority for this Strategy was to develop training and tools for key change agents. Change agents in this context are generally community members who promote behaviour change in communities. It will be important to equip these change agents with the knowledge, skills, resources and materials they need to be effective. They need orientation to harmonize messages, to gain effective communication skills and to understand the role they play in a national system of health promotion. For instance, Community Health Workers (CHWs) require manuals and job aides, which are currently being revised and disseminated. Healthcare workers need counselling aids. Everyone agreed that these change agents can benefit from even small key message guides. See *Objective 2. Strengthen National Health Promotion Interventions* for more information.

Media and Mobilization Approaches

In May 2016,HC3 conducted an informal survey among 23 health promotion partners, which indicated that existing health promotion activities covered a full gamut of health areas and interventions, mostly focusing on maternal and child health issues. Specifically, most activities focus on antenatal care (ANC), water, sanitation and hygiene (WASH), cholera and/or diarrhoea. While mass media, interpersonal communication methodologies and community mobilization interventions were widely employed as communication channels, only some said they engaged in advocacy, community surveillance and newer technologies for health communication, such as mobile phones and short message service (SMS) technologies. Further, consultations revealed that mass media (e.g., radio, television and mobile[2]) programmes are often the products of a single station or implementing organization.

As this Strategy is implemented, it has been agreed that the MOHS will commit itself to collaborating on key mass media programmes, so the impact can be expanded and more programmes can benefit from the support. It is interesting to note that a number of health projects have introduced smart phones and tablets for community-level surveillance, facility-based data collection and other activities (Wittels, 2016); however, most people still turn to radio as their primary source of information.

Importantly, a number of community-level interventions have proven to be effective, namely community engagement, health fairs, drama groups, the involvement of local celebrities and the enactment of local by laws. See *Objective 2. Strengthen National Health Promotion Interventions* for more information.

Key Behavioural Determinants

Consultation participants also considered which “intermediate variables” tend to drive health behaviours in Sierra Leone. Intermediate variables refers to the factors that would be most likely to lead to improved behaviours and create or support an enabling environment, if the MOHS and partners were to affect them with health promotion efforts.

[2]83 percent of Sierra Leoneans either owned a mobile phone or have one in their household available for their use (DHS, 2013; Wittels, 2016)

Participants considered and debated the importance of eight potential determinants:

1. Availability of quality health services
2. An enabling environment for health promotion
3. Traditional and religious values
4. Perceived value of health services
5. Sense of personal risk for health problems
6. Family decision making
7. Self-efficacy or self-confidence to take action about one's health
8. Perceived social support for key reproductive, maternal, newborn and child health behaviours

Of these, the highest rated were,"3. Traditional religious values," followed by "4. Perceived value of health services." See *Objective 2. Strengthen National Health Promotion Interventions* for more information.

Human Resources and Capacity Strengthening

Addressing human resource constraints in Sierra Leone will help remove barriers to implementing consistent high-quality health promotion programming at scale.

The HED is comprised of a small core of dedicated full-time staff at the national level. However, the number of qualified full-time personnel is very limited – namely, two staff members at the head office, one in Disease Prevention and one in Malaria. Those staff are supplemented with staff from other disciplines posted to HED, other MOHS staff in related disciplines such as community health, facility-based or linked health workers responsible for community outreach (such as maternal and child health [MCH] Aides and CHWs) and the work of voluntary sector members of the SM and media and communications committees.

In most districts, the District Health Management Team (DHMT) includes a SM Coordinator and, at times, a working SM Subcommittee. Their work is supplemented by the various organizations involved in Village Development Committees (VDCs) and Facility Management Committees (FMCs).

Taken as a whole, these professionals have had marked success. For example, they were instrumental in turning back the Ebola threat. However, they recognize that their numbers are too few; their training is occasional and conducted on an as-needed basis with an emphasis on in-service rather than pre-service training; and their professional profile and career path are unclear. Some examples of the occasional in-service training programmes that have been conducted include WHO Compassionate Communication, Johns Hopkins Leadership in Strategic Communication and various UNICEF trainings, including data for decision making. See *Objective 3. Improve Human Resources and Capacity Strengthening for Health Promotion* for more information.

Advocacy and Resource Mobilization

A clear consensus was reached among government and NGO partners during consultations that the HED, and health promotion in general, are seen as a "spare tyre" within the health system, and suffer from a lack of financial and political support.

To illustrate this point, consider that health promotion officers have had to use their own resources – including vehicles, mobile phones, laptops and other equipment – to perform their jobs. Additionally, the capacity of health promotion officers needs to be strengthened, but no system is in place to provide continual and sustained capacity development. Ironically, these limited resources are largely to blame

for health communication not being seen as a key public health intervention. As such, raising the visibility of the benefits of health promotion and mobilizing resources for health promotion activities – and the HED – will be an important part of this Strategy. Advocacy efforts need to point to research that health promotion improves knowledge and practice of optimal health behaviours, which can then reduce high national maternal and neonatal mortality rates. See *Objective 4. Raise Awareness and Mobilize Resources for Strengthened Health Promotion* for more information.

Monitoring and Evaluation and Knowledge Sharing

Within the country, M&E activities rely on a partially functional and largely disparate set of data collection and reporting systems consisting of a wide variety of paper-based, electronic and verbal platforms that are generally not shared across partners. When asked about current M&E systems, the MOHS HED and partners named a variety of epidemiological studies they use to inform health promotion programmes, such as the DHS and the National Nutrition Survey and the Malaria Indicator Survey (MIS), as well as specific studies conducted by implementing partners such as the Focus 1000-led Ebola Knowledge, Attitudes and Practices (KAP) studies, the British Broadcasting Corporation (BBC) Media Action audience survey and mobile data collection tools from UNICEF and other partners such as UReport, Rapid Pro and others.

Although specific issues can be addressed with each system, there are common problems related to insufficient human and financial resources for operation, poor supervision and monitoring and a lack of knowledge management and data sharing mechanisms. Through the consultations, partners advised that the MOHS – through the Directorate of Policy, Planning and Information – should track the progress of health promotion activities with a set of standardized health promotion indicators, and that it should develop a robust community-based health information management system because community-based data collection is currently not being used or shared effectively. See *Objective 5. Improve Monitoring and Evaluation Systems for Health Promotion* and *Objective 6. Strengthen Knowledge Sharing and Management* for more information.

2010 National Health Promotion Policy Review

Sierra Leone has a solid foundation of policy and programme guidance on which to develop this five-year strategic health promotion plan. The **2000 Health Education Policy** placed health promotion firmly on the national agenda. That policy called for the establishment of a HED within the MOHS and emphasizing the importance of integrating health education into primary health care.

In 2010 that policy was succeeded by the **National Health Promotion Policy**. The MOHS developed the 2010 Policy with assistance from the WHO, UNICEF, Cooperative for Assistance and Relief Everywhere (CARE), Catholic Relief Services, the College of Medicine and the Fatima Institute. This new policy raised the profile of health promotion on the national agenda. In May 2016, the MOHS convened a meeting of various staff within the Ministry and a number of NGO partners to discuss the progress that had been made on implementation of the policy. The group discussed 11 areas highlighted by the 2010 Policy. See *Appendix B. Review of National Policy and Guidance* for more information.

Conclusion

The National Health Promotion Strategy (2017–2021) was constructed based on the consultations that, in large part, formed this situation analysis. The heart of the Strategy is to build a high-quality health promotion division within the MOHS, which can then more effectively provide guidance to district-level implementers and partners.

SITUATION ANALYSIS

The civil war that ended in 2002 weakened Sierra Leone's health system. In the years that followed, the MOHS developed a decentralized health system structure that delegated power and responsibilities to local councils. DHMTs, which were developed prior to this time period (formed in each of the country's 14 districts), provided support for the country's19 local councils and 149 chiefdoms.

In 2010, in a major effort to further strengthen the health system, the MOHS introduced a Free Health Care Initiative (FHCI) along with a Basic Package of Essential Health Services (BPEHS) for pregnant and lactating women and children under age five in order to improve maternal and child health, adding free malaria testing and treatment a year later. The FHCI initially substantially increased demand for health services, which resulted in improved rates of maternal and child health (DHS, 2013); however, drug stock outs and service gaps later strained public trust in the system. In 2011, performance-based financing (PBF) was introduced to encourage healthcare providers to increase the quality of services (Sierra Leone Ministry of Health, 2013; Bertone et al., 2016).

The role of health promotion within the health system has also evolved steadily since the inception of the HED of the Directorate of Primary Health Care (DPHC) in 1978.For instance, the HED's early role focused on developing and implementing training and information, education and communication (IEC) materials. As a national partner for health promotion and social and behaviour change communication (SBCC) activities in country, the HED now oversees the implementation of all health promotion activities at the central and district level, which includes message development and dissemination, community engagement and SM, mass media campaigns and other related SBCC activities. With the exception of national immunization and insecticide-treated bed net (ITN) distribution campaigns, the majority of SBCC activities occur at the community level.

Between the end of the civil war in 2002 and the start of the Ebola outbreak in 2014, the HED and various technical health programmes in the MOHS coordinated SM and health promotion activities. These activities were primarily conducted through implementing partners, with few SBCC programmes that supported health systems strengthening. The HED managed a number of health promotion committees to help coordinate partner activities on the ground, mechanisms that were largely replaced by the pillar structure under the National Ebola Task Force set up during the Ebola outbreak, and led by the MOHS.

The pillar structure was created during the outbreak largely to coordinate and manage government and partner activities. The health promotion pillars – including the Social Mobilization Pillar and Media and Communications Pillar – demonstrated their importance in managing partner activities and fostering a sense of community ownership of health through effective mass media and, most importantly, community engagement approaches.

For instance, SM efforts built confidence in communities by mobilizing and empowering them through dialogue as partners in the Ebola response. These dialogic approaches began early in the outbreak, and were taken to scale by November 2014 (Social Mobilization and Advocacy Consortium [SMAC], 2015).However, response agencies initially did not prioritize a focus on local structures and community dialogue within individual communities, preferring more immediate, visible activities such as media campaigns and poster distributions. Ultimately, gaining community ownership to address the issues through SM was an undeniable necessity.By December 2014, new case numbers started dropping (WHO, 2015), and there was growing recognition that SM would be central to effectively reach "zero Ebola."

Since the end of the Ebola outbreak, these pillars still exist but with waning membership. Efforts to rejuvenate and broaden their focus are ongoing.

Sierra Leone's Health Promotion Structures

Under the leadership of the HED, the SM Pillar has expanded its mandate to focus on a variety of health areas, such as maternal and infant mortality, in addition to preparedness and response to disease outbreaks (e.g., malaria, measles, Ebola and cholera) and disaster management (e.g., flooding and famine). The HED serves as the Chair of the SM Pillar Secretariat, and membership of the SM Pillar includes UN organizations, NGOs, civil society organizations (CSOs), donors, media representatives, traditional leadership, line ministries, inter-religious councils, voluntary organizations, training institutions and district SM coordinators.

Further, the SM Pillar is the principal coordinating body to ensure harmonization of SM and community engagement efforts to raise awareness and demand for health services, influence healthy behaviours at the household level and increase community ownership of health and development outcomes. The pillar's terms of reference (TOR) define three main areas of technical support:

- Coordination to ensure SM efforts are harmonized and maximize reach, quality and consistency
- Materials development and dissemination through development, review and approval of all health promotion messages generated in country
- Evidence generation and data usage for making decisions (MOHS, 2016)

Given the need for greater coordination, data and knowledge sharing, and standardization of messages and approaches, rejuvenating and strengthening the national- and district-level SM Pillars will be a key activity for this Strategy.

Given the HED's staffing and capacity challenges, the MOHS relies primarily on partners such as UNICEF, the United Nations Population Fund (UNFPA) and WHO for capacity building and technical support, and to assist in ensuring health promotion activities are being implemented effectively. UNICEF's Communication for Development (C4D) unit currently leads technical support on the SM Pillar. C4D has been instrumental in efforts to strengthen coordination and management structures and to meet the MOHS's goals for mechanisms that strengthen community ownership. UNFPA supports the HED in promoting reproductive health, and is the support lead in the MOHS Reproductive Health and Family Planning Communication Technical Working Group, which meets on an as-needed basis. WHO provides technical and capacity building support for a number of health promotion issues including tobacco control, policy and strategy development and training.

It is important to stress that, according to the DPHC, health promotion is the key role for the nation's CHWs. Under the DPHC, the National CHW Hub is responsible for the National CHW Program, which provides guidelines on policy, strategy, financing and implementation as well as guidance related to CHWs. The National CHW Hub also facilitates the CHW Steering Committee and a CHW Technical Working Group (TWG). These national structures, which serve to ensure implementation of the CHW strategy and advise on coherence and complementarity, also link with district-level CHW TWGs and a CHW focal person. Membership includes all MOHS Directors and Program Managers whose programmes are implicated in the National CHW programme, including the HED.

An overview of the activities and responsibilities of the HED, the SM Pillar – at the national, district and community levels – and other key pillars is contained in Table 1.

Table 1. Key Health Promotion Structures

NATIONAL LEVEL

Health Education Division

- As a division within the DPHC, the HED serves as a national partner for health promotion and SBCC activities
- Oversees and manages the implementation of all health promotion activities in the country
- Supported by numerous NGOs and CSOs
    - Coordination mechanisms to share best practices include the Health NGO Forum, the International Health Forum and the Health and Nutrition Civil Society
    - Donors such as the United States Agency for International Development (USAID), the United Kingdom's Department for International Development (DFID), Irish Aid and others meet in regularly scheduled donor partner meetings to ensure efforts are coordinated

National Social Mobilization Pillar

- Supported by 14 District SM Pillars, the National SM Pillar is the principal coordinating body to ensure harmonization of SM efforts, providing technical support on materials development and dissemination, review and approval of health promotion messages, evidence generation and data usage for making decisions.
- The HED serves as the chair of the SM Pillar Secretariat. As of this writing, UNICEF is the co-chair. The HED participates in key pillar and hub meetings to ensure harmonization of activities.
- The pillar was re-activated during the Ebola outbreak, but has since evolved to include a variety of health areas, such as maternal and infant mortality as well as preparedness and response to disease outbreaks (e.g., malaria, measles, Ebola and cholera) and disaster management (e.g., flooding and famine).
- A TOR document serves as a guide for the National SM Pillar.

Communications Pillar

- As part of the Public Health National Emergency Operations Centre (PHNEOC), this pillar is designed to develop and implement emergency communication preparedness plans, with a focus on media and public information.
- A health promotion officer from the HED attached to the MOHS Directorate of Disease Control and Prevention serves as the Communications Pillar lead and chair.
- A TOR document serves as a guide for the Communications Pillar.

Inter-Pillar Meetings

- Representatives from the Communications Pillar and the SM Pillar meet during scheduled inter-pillar meetings and an HED health promotion officer attends all three pillar meetings to ensure harmonization.

National Community Health Worker Hub

- Under the leadership of the DPHC, the CHW Hub is responsible for the National CHW Program, which provides policy, strategy, financing, implementation guidelines and guidance related to CHWs.
- Given the Ministry's prioritization of the development of CHWs, and the trust local communities have in them, these change agents are critical health promoters at the community level.

Community Health Worker Steering Committee and Technical Working Group

- These national structures, which serve to ensure implementation of the CHW strategy and advice on coherence and complementarity, also link with district-level CHW TWGs and a CHW focal person.
- Membership includes all MOHS directors and programme managers whose programmes are implicated in the national CHW programme.

DISTRICT LEVEL

District Health Management Team

- Responsible for operationalizing health policy, which includes liaising with respective local councils and central-level ministries for resource allocation and budget requests
- Initiates quarterly community meetings with local stakeholders to identify the gaps in the health system and propose solutions
- Mobilizes resources for health promotion and other health services activities allocated by the District Council

District Council

- Distributes resources across the public sector

District Pillars

- Each district has a District SM Pillar linked to the national SM Pillar responsible for implementing and overseeing district-level SM activities for health
- To aid in disease surveillance and coordination of health promotion activities, each district also has a District Surveillance Pillar; a District Health Coordinating Committee; a District Infection, Prevention and Control Committee; a District AIDS Committee; a District Rapid Response Team; and other related committees that work closely with the District CHW TWG, which includes a District CHW focal person

Community Health Worker District Technical Working Group

- Ensures that national-level priorities related to the CHW programme are implemented at the district and local level
- The MOHS mandated that at least one CHW must serve as the link between the health facility and the community it serves

COMMUNITY LEVEL

Peripheral Health Units

- Peripheral Health Units (PHUs) are delivery points for primary health care in the country.

Health Management Committees/Facility Management Committees

- Oversees the functioning and supply of the PHUs at the district level, also known as the FMCs.
- Each district has either as a Health Management Committee (HMC) or an FMC, which is composed of seven to 11 members appointed by the community.

Village Development Committees

- Oversees all development initiatives in communities, including health services and health promotion, environment, leadership, education and other issues. CHWs are members of the VDCs.
- A TOR document serves as a guide for the VDCs.

Community Groups

- CHWs and representatives from a variety of community groups are attached to the VDCs in each community, and are regularly employed to promote health and sanitation issues.
- This group must include (but should not be limited to): traditional leaders, ward councillors, societal heads, traditional healers, religious leaders, women's secret societies, men's secret societies, women's leaders, youth groups, women's clubs, market women, community health clubs, school health clubs, school management committees and mother-to-mother groups. These representatives are instrumental for health promotion activities and efforts to strengthen or, where necessary, revitalize them, will be critical.

Ebola's Impact on the Health System

In 2014, the approximately year-long Ebola outbreak further challenged the health system. In addition to over 14,000 cases of Ebola and nearly 4,000 deaths in Sierra Leone, the prevalence and severity of other health conditions rose during the outbreak. Resources normally allocated to a range of health conditions were diverted to stop the outbreak, causing health facilities to close or function poorly due to extreme understaffing and inadequate stocks of supplies and medicines (UNICEF, 2014). These factors and others – such the association of health facilities with Ebola – contributed to a decline in the utilization of healthcare facilities and a loss of trust in the health system. All this led to plans to strengthen the health system as part of a recovery process, culminating in the *National Ebola Recovery Strategy for Sierra Leone (2015–2017)* and the broader *Health Sector Recovery Plan (2015–2020).*

The Government of Sierra Leone is not only attempting to restore routine and essential health care, but also learn from the Ebola epidemic in order to prevent other emergency outbreaks. Some steps have already been taken to prevent future disease outbreaks. For instance, a major vaccination campaign took place in June 2015 to vaccinate 1.3 million children against measles and polio (WHO, 2015). With cases of yellow fever reported in neighbouring countries and the country's susceptibility to cholera, increased attention is being paid to these and other infectious diseases, especially as the health system is still in the early phases of rebuilding following the Ebola outbreak.

The MOHS is now also placing greater emphasis on strengthening health systems and **community ownership** as a means to improve health outcomes, which is outlined in the *Health Sector Recovery Plan*. Even in 2010, the *MOHS Basic Package of Essential Health Services for Sierra Leone* – a guiding document for service delivery in all primary and secondary public health care settings – noted that while many individual services were available at the community level, "there was not one coordinated and harmonized community health programme."

The updated 2015 BPEHS describes community ownership as a "movement to encourage communities and individuals to take ownership of their own health and of their responsibilities in supporting a functioning health system." This requires "raising awareness on health issues, sensitizing community leaders on their roles and responsibilities and strengthening community groups such as community health clubs, mother-to-mother support groups, community/neighbourhood watch groups for disease surveillance and engagement of youth and men in women's and children's health issues," according to the BPEHS.

Pregnant women, new mothers, infants and children are particularly vulnerable after the Ebola outbreak. Now is an appropriate time to assess the health landscape to identify challenges and priorities to improve health conditions for al lpeople, but particularly for women and children.

Key Reproductive, Maternal, Newborn, and Child Health Data

While behavioural data is still limited, the following key health issues are considered priorities by the government and partners. Additional health areas being addressed are included in *Appendix A.Additional Health Landscape in Sierra Leone.*

<u>Maternal, Neonatal and Under Five Mortality</u>

While major improvements have been seen over the years in these areas, Sierra Leone still has one of the highest rates of maternal and neonatal mortalities. In 2015, WHO estimated the maternal mortality ratio to be 1,360 deaths per 100,000 live births. Haemorrhaging or heavy bleeding causes an estimated

one-third of maternal deaths; another 11percentare related to malaria or anaemia caused by malaria. Nationwide, 6percentof women die while pregnant, in delivery or after birth (DHS, 2013). While these conditions are treatable, infrastructure and financial barriers frequently keep women from attending a facility for delivery and from receiving necessary services and medicine for prevention.

During the Ebola outbreak, fears of catching the disease contributed to keeping women away from facilities providing maternal health care, including deliveries. As a result, according to a Voluntary Services Overseas (VSO) study, maternal deaths increased by 30percentduring the outbreak (VSO, 2015).

Along with high rates of maternal mortality, the infant and child mortality rates in Sierra Leone are also among the highest in the world. While the infant mortality rate has decreased significantly in the past decade, of 1,000 live births there are an estimated 35 deaths within the first month of life (WHO, 2015) and an estimated 92 deaths before the infant reaches one year (DHS, 2013). Unfortunately, during the Ebola epidemic newborn deaths increased by 24percent, largely due to a decline in facility deliveries (VSO, 2015).The under-five mortality rate varies by source but was estimated at 156 deaths per 1,000 live births (DHS, 2013).

Most cases of infant and child death are preventable, with the majority being attributed to malaria, diarrhoea and pneumonia. For example, 55 percent of under-fives do not sleep under an ITN (MIS, 2013),3 percent of children with diarrhea did not receive any treatment (DHS, 2013), and 15 percent of children are not treated with oral rehydration salts (ORS) (DHS, 2013). According to the WHO (2015), 41 percent of deaths of children under five are due to malaria.

Reproductive Health, Family Planning and Teenage Pregnancy

Within the country, there is almost universal knowledge of at least one modern contraceptive method. One-quarter of women have an unmet need for family planning, with 17percentdesiring to space future births and 8percentdesiring to limit births (DHS, 2013). While precise numbers are not known, this unmet need likely increased during the Ebola outbreak.

The 2013 DHS revealed that 28percentof adolescents (aged 15 to19) have begun childbearing and teenage pregnancies account for more than one third of all pregnancies in the country. Over half of all women have become mothers by age 20 (DHS, 2013). In addition to the non-fatal complications that younger women are more susceptible to in pregnancy and delivery, teenagers in Sierra Leone also are at the highest risk of maternal mortality of any age group, with 40percentof maternal deaths occurring with teenage girls (MICS, 2010).The high rates of teenage pregnancy are closely related to the prevalence of early marriage, as early marriage is seen as a protection mechanism for girls against involvement in extra-marital sex (Coinco, 2010). Further, 31 percent of adolescents reported having sex before the age of 15 (MoHS, 2016).

Reducing teenage pregnancy is one of the government's key health priorities. Many reports have indicated an increase in unplanned pregnancies – particularly among teenagers and a decrease in uptake of family planning services during the Ebola epidemic.

Care-seeking Practices

While a growing number of people trust and use health facilities, transportation and costs remain barriers, and people typically seek out traditional medicines or go to a pharmacy for medication before

diagnosis (Wittels, 2016). Nevertheless, nearly all pregnant women in Sierra Leone received ANC from a skilled provider and three-quarters of women had at least four ANC visits[3](DHS, 2013); however, more than half waited until at least their second trimester of pregnancy to make their first ANC visit (DHS, 2013). Generally, people tend to seek medical attention and consider going to a facility when symptoms become severe or a more dangerous illness is suspected (DHS, 2013). Reports about awareness of danger signs in pregnancy are mixed; when women are aware of danger signs, they often do not identify them as requiring care at a facility (Kanu et al., 2014; Oyerinde et al., 2011).

Between 2008 and 2013, the percentage of facility deliveries more than doubled, from 25 to 54percent of births (DHS, 2013). However, many studies have noted that in Sierra Leone, a "normal" delivery is synonymous with home delivery (Oyerinde et al., 2013; Treacy & Sagbakken, 2014). The hospital is seen as the place to go only in the case of complications rather than all deliveries. Facility deliveries are more common in urban areas compared to rural areas, and there is also a correlation between receiving four or more ANC visits and facility delivery. However, a number of factors and barriers may lead to delivery at home. Women who have already had multiple children are more likely to deliver at home (DHS, 2013), and delays in telling others that labour has begun may result in some women not making it to a facility in time for delivery (Treacy & Sagbakken, 2014).

In terms of postnatal care (PNC), it is promising that about three-quarters of women in Sierra Leone received PNC within two days of delivery[4] (DHS, 2013); however, this same report also revealed that over half of newborns received no postnatal check-up within two days of birth, pointing to a need for further examination of this gap between the number of mothers attending PNC and infants being taken for their check-up.

[3]However, 24 percent of women did not make at least four ANC visits (DHS, 2013).
[4]Twenty-seven percent did not receive a post-natal check-up within the recommended days (DHS, 2013).

OBJECTIVE 1. STRENGTHEN HEALTH PROMOTION STRUCTURES

The Government of Sierra Leone has numerous structures with roles and responsibilities in health promotion. These structures are described in more detail in the Situation Analysis.[5]While many of these structures were active during the Ebola outbreak, where they played an essential coordinating role, many have since become dormant. Government and non-governmental partners alike are calling for the revitalization of those mechanisms, emphasizing the importance of building technical capacity to effectively manage and increase coordination among all health promotion structures. It is noteworthy that key health promotion partners, such as UNICEF and WHO, a real ready working with national- and local-level structures to clarify roles and increase effectiveness. These efforts will be a critical building block toward strengthening community ownership as part of the MOHS recovery plan.

SO 1.1: Rejuvenate the Social Mobilization and Communication Pillars at National Level and Strengthen Coordination Mechanisms

To strengthen national-level structures to address a variety of health issues in the country, strategic priorities include formalizing the SM and Communication Pillars through TORs and strategy documents, which must align with the MOHS Community Engagement Strategy and CHW policies and guidance. These formalized documents will include mandates about vetting communication messages and materials through these structures. To maintain a level of excellence and achieve success according to the TORs, on-going behaviour change communication leadership and management capacity building will be provided to these pillars.

Major activities for this sub-objective (SO):

1.1.1	Review, Update and Disseminate SM Pillar TOR
1.1.2	Review, Finalize and Disseminate the Communications Pillar TOR
1.1.3	Hold Monthly (More as Necessary) National SM Pillar Meetings
1.1.4	Hold National Communications Pillar Meetings (PHNEOC) Every Two Weeks
1.1.5	Participate in Inter-pillar Meetings at National Level Called by PHNEOC for Improved Coordination
1.1.6	Conduct Periodic Capacity Assessment for Strengthening National SM and Communication Pillars and Provide Support

SO 1.2: Rejuvenate the Social Mobilization Pillar at District Level and Strengthen Coordination Mechanisms

The HED will also revitalize and strengthen district pillars – key to coordinating health promotion activities and messages, and ensuring a functioning feedback loop between the district and national level. As such, strategic priorities will include conducting a stakeholder mapping meeting to identify the gaps in information flows and develop a plan to address them, ensuring that roles and responsibilities of the key health promotion structures at all levels are defined, including how they share information.

[5]Informal structures include traditional healers, traditional birth attendants, unlicensed drug peddlers and pharmacies. During the Ebola outbreak, a ban on using unlicensed health providers was enacted; however, evidence suggests this drove practices underground, so it is important to understand how to work with them in a safe and effective way.

Importantly, there is a need for on-going training in health promotion leadership for the DHMT so they can provide greater guidance to partners, including civil society at the local level. During emergencies, it is critical that a trained health promotion officer is stationed at the district level. Multiple organizations will be conducting district-level health-promotion-related training. As these trainings roll out, care will be taken to not duplicate efforts – combining efforts wherever possible – and to ensure that trainings are complementary to each other.

Major activities for this SO:

1.2.1	Review, Update and Disseminate District Level SM Pillar TOR
1.2.2	Map Active SM Pillar Partners and Identify Dormant SM Pillars
1.2.3	Hold a Revitalization Meeting to Present Mapping Landscape with Recommendations, TOR and Roles/Responsibilities
1.2.4	Conduct Two-Day Capacity Assessment Meetings and Support (e.g., Training) for All District SM Pillars
1.2.5	Hold Monthly District-level SM Pillar Meetings (More Frequently as Needed) and Circulate Meeting Minutes
1.2.6	Attend Monthly District Coordination Meetings in Person and Include HP on the Agenda, While Serving as Health Advocates
1.2.7	Map and Develop MOUs with Functional Community Radio Stations in Each District for Message Dissemination
1.2.1	Review, Update and Disseminate District Level SM Pillar TOR

SO 1.3: Strengthen Community-level Actors and Foster Community Ownership of Health

One of the primary lessons learned from the 2014-2015 Ebola outbreak was the power communities have to lead the change toward improved health and wellness. Structures to oversee and manage certain aspects of health communication continue to exist in communities. Each PHU has a CHW serving as the link between the facility and the community. HMCs, also known as the FMCs, oversee the functioning and supply of the PHUs. VDCs oversee all development initiatives in communities, including health services and health promotion. Representatives from community groups are attached to each VDC and regularly promote health and sanitation issues. Community groups are instrumental for a variety of health promotion roles. As such, strategic priorities include rolling out integrated health promotion training and guidelines to these community-level structures and groups. For instance, conducting trainings to clarify the VDCs' and associated community groups' health promotion roles and strengthening them in this role or holding a series of community stakeholders meetings to develop a system for feedback between the community and appropriate district and national structures (this could be based on the mapping exercise noted above). DHMTs will be held accountable for ensuring the feedback loop system is in place and functioning as planned.

Major activities for this SO:

1.3.1	Develop and Disseminate Guidance on HP Roles and Responsibilities for Community Structures (e.g., VDCs, HMCs/FMCs, CHWs, Community Groups, etc.)
1.3.2	Support Integrated Training on HP Roles/Responsibilities for VDCs/HMCs/FMCs and Community Structures

OBJECTIVE 2. STRENGTHEN NATIONAL HEALTH PROMOTION INTERVENTIONS

One of the benefits of creating a national strategy for health promotion is that it can add value to the work of individual actors and agencies, and ensure linkages to national health priorities. The following "areas for common action," validated by national stakeholders during a series of consultations, represent opportunities to increase national programme impact and quality:

1. Models for implementation
2. Intended audiences for our programmes
3. Key change agents
4. Typical health promotion interventions
5. Key behavioural determinants
6. Collaboration with all technical units of the Ministry on their priorities for health promotion
7. A national umbrella campaign
8. An emergency communication plan
9. Amultisectoral response

In each of these nine areas, if several implementers coordinate with each other, the whole of our national effort will truly be greater than the sum of its parts.

To inspire broad "buy in" and increase programme quality, national health promotion efforts will adopt proven models to guide programme implementation. Two models that have been field tested in many settings similar to Sierra Leone are the **P-Process™** and the **Social Ecological Approach to Change**.

The P-Process describes the crucial steps in programme implementation that are required to guide strategy development (see Figure 1 at right). This step-by-step road map leads communication professionals from a loosely defined concept about changing behaviour to a strategic and participatory programme with a measurable impact on the intended audience. As programme managers proceed through the project cycle, they must reflect on how much participation – from both implementation partners and the audience themselves – they are inspiring. In addition, programme managers need to understand what capacity building needs are apparent in order to be able to follow the process productively and ensure that efforts are strategically designed, resonate with intended audiences and have the necessary impact.

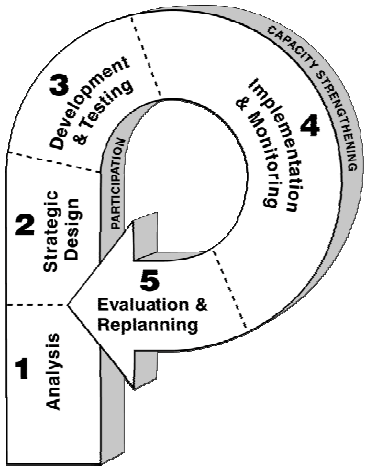

Figure 1: P-Process

As part of the P-Process, implementers first analyse the programme environment and public health situation. They then work on the strategic design of the programme, including making key decisions about the intended audience and the channels to reach that audience. The next step is to develop programme elements, testing them with the intended audience and then retesting them after incorporating feedback. In the implementation and monitoring phase, adequate real-time monitoring is often neglected and its value needs to be emphasised. Finally, in evaluation and re-planning,

programme managers uncover whether their efforts have achieved their objectives, explain why (or why not) objectives were not reached and use their conclusions to re-plan the next phase of action.

Another programming model that will be helpful to those implementing the National Health Promotion Strategy is built on the Social Ecological Approach to Change. It is a reminder that comprehensive programming operates in the enabling environment, the service delivery system and the community and individual domains. Figure 2 (below) is an example of a framework that was developed by CCP for a malaria communication campaign. By depicting the three levels of intervention, all actors in a coalition of organizations can understand where they fit in the national campaign strategy. By populating the model with specific indicators in the third and fourth columns, it can be useful to monitor programme progress and track ultimate impact.

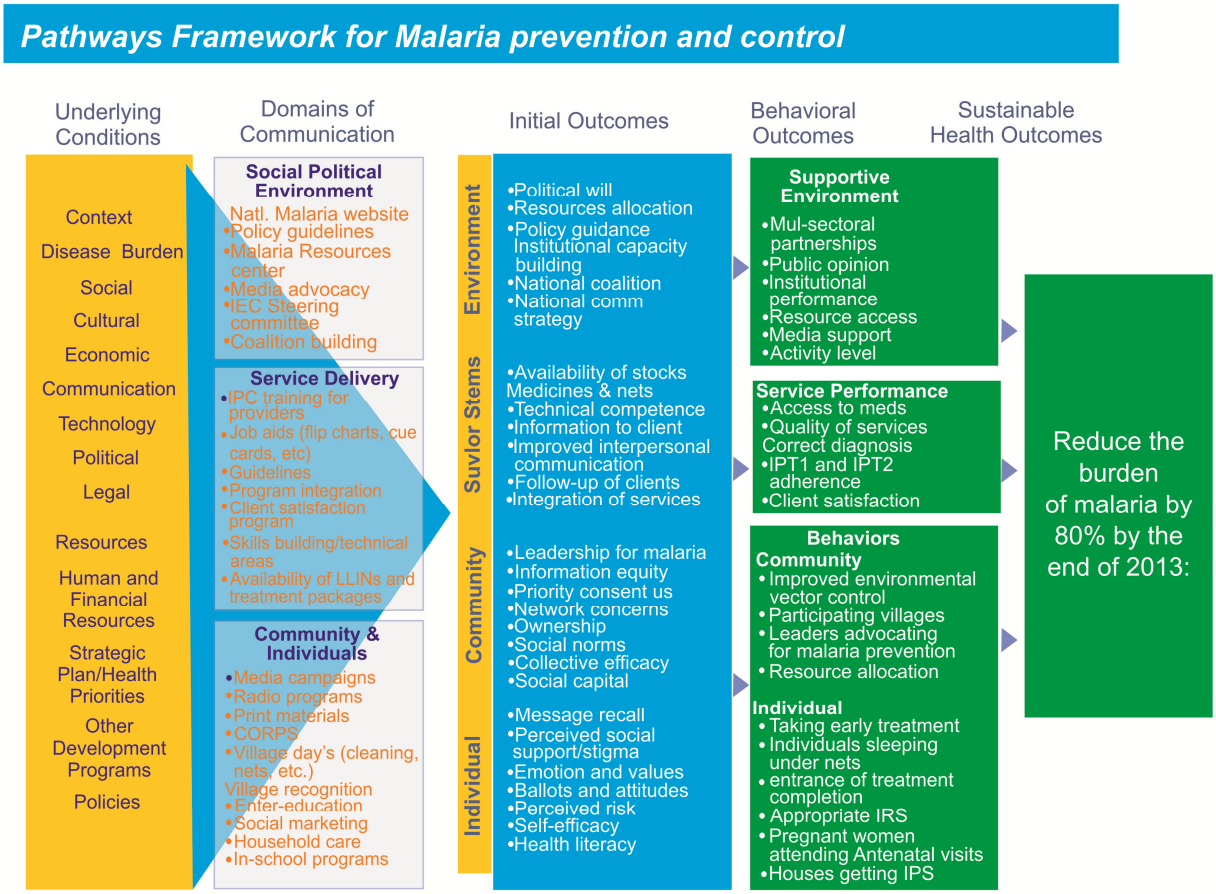

Figure 2: Sample Pathways to Improved Health Outcome

SO 2.1: Disseminate and Provide Guidelines on the Use of Health Promotion Models

Given the health promotion models described above, strategic priorities will include creating information materials about effective health promotion models; consistently adopting and adapting evidence-based models for health promotion programming; and orienting partners toward using these models in their programming. Activities should address accountability of partners and programmes adopting these models, either through the service-level agreement (SLA) process or some other mechanism.

Major activities for this SO:

2.1.1	Develop and Disseminate HP Model/Pathway Brochure and Orient Partners on HP Model/Pathway and Other Guidance through Standing Pillar Meetings
2.1.2	Hold Regular MOHS Stakeholders Meetings to Include a Mandate in the SLA for Partners to Base Programming on Approved HP Model/Pathway, and Other Guidance Documents (e.g., SM TOR)

SO 2.2: Support National Integrated Efforts to Reach Adolescents with Health Promotion

Based on a review of national issues and priority audiences among the technical experts (see the *Background* section), the **national priority audience for this Strategy is older adolescents (ages 15 to 19)** with younger adolescents following close behind in second place. Targeting this group alone, however, will be insufficient as they are the most vulnerable and disenfranchised. Imploring them directly to change their behaviour will likely be unproductive without simultaneously mobilizing all audiences that support young people as they strive to make the healthiest choices they can.

Given that many players are undertaking efforts to reach adolescents, the coordination role of the Ministry, pillars and coordinating committees will be crucial in pursuing the national priority to reach this audience. Therefore, to support an integrated effort to reach older adolescents and secondary audiences with health promotion, national strategic priorities include identifying and filling gaps in evidence, supporting and strengthening adolescent-focused campaigns and supporting advocacy to gain buy-in at the national and district levels.

Major activities for this SO:

2.2.1	Gather and Share Existing Evidence with National and District Partners on Adolescent Health Behaviors through HED Knowledge Gateway
2.2.2	Conduct Bi-annual Meetings between HED and the National School Adolescent Health Program/Secretariat of Teenage Pregnancy to Strengthen Collaboration
2.2.3	Support Adolescent Campaign Design and Implementation
2.2.4	Support Advocacy on the Need to Reach Adolescents (e.g., Religious and Community Leaders)
2.2.5	Facilitate Community-level Adolescent-Focused Program Activities

SO 2.3: Strengthen Community-level Actors in Health Promotion

Another area for common action is to improve the health promotion role of key community change agents. Key change agents within the community and health infrastructure in clued CHWs, health promotion coordinators, healthcare workers, committees and organizations (such as the VDCs and FMCs), drivers' unions, market women's associations and others. Importantly, they also include community leaders such as traditional leaders, market women, women's group leaders, youth group leaders, social heads, bike riders, traditional healers and teachers.

Given the Ministry's prioritization of the development of CHWs, and the trust local communities have in them, these change agents are critical health promoters at the community level. To strengthen the role of community change agents, national strategic priorities include surveying available materials and orientation schemes for key change agents, reproducing quality existing materials and creating new materials and programmes where necessary, while also providing training on using job aids and tools. It is also recommended to do this activity for in-service healthcare workers for strengthened interpersonal communication skills, providing training on interpersonal communication and how to use job aids and tools, and providing follow-up support.

Major activities for this SO:

2.3.1	Conduct Mapping of Materials/Job Aids for Community-level Actors and Supporting Partners to Identify Gaps
2.3.2	Develop Health Promotion Materials/Job Aids for Community-level Actors Based on Mapping/Review
2.3.3	Provide Opportunities (Training) for Community-level Actors to Use Health Promotion Materials and Become Health Promotion Advocates
2.3.4	Conduct Mapping of Materials/Job Aids for In-service Healthcare Workers to Identify Gaps
2.3.5	Develop Health Promotion Materials/Job Aids for Interpersonal Communication Skills for In-service Healthcare Workers
2.3.6	Provide Training for In-service Healthcare Workers on Interpersonal Communication Skills and Using Job Aids/Materials and Provide Follow-up Support (Incentives, Mentoring, Supportive Supervision)

SO 2.4: Establish Evidence-base on Behaviours and Communication Channels to Guide Programming

Strategic priorities will focus on identifying, assessing, gaining and sharing evidence on behavioural determinants and communication channels and investing in those that work.

However, in the meantime, the HED and all health promotion partners must consider the key behavioural determinants, for example:

Priority Behavioural Determinants	Secondary Behavioural Determinants
Perceived "traditional religious values" and "value of health services" as being particularly influential.	Traditional views regarding gender norms that hamper health promotion – for instance, that men generally have overriding decision-making power.
	The influence of grandmothers and mothers-in-laws, even though they are not often the most knowledgeable about health information.

Strategic priorities will include assessing and selecting a few platforms that can serve multiple health needs and multiple partners, and investing in those select interventions. It also includes investing in or advocating for additional research on key behavioural determinants related to priority audiences and health areas to validate or strengthen the evidence that exists in this area, and to document and share that evidence with other key partners. Further, the HED will lead the coordination ofNGOs, broadcast partners and national production partners around communication channels via the communications pillar and to share data and broadcast feedback. Using donor organizations as influential champions, the HED will mobilize resources to co-finance the production of a national radio and TV show that collaborates with local partners for local content.

Major activities for this SO:

2.4.1	Conduct Desktop Analysis to Identify Evidence Gaps on Knowledge, Attitudes, Practices and Behaviors Related to Priority Health Areas and Audiences
2.4.2	Support the Design, Implementation and Dissemination of Studies to Fill Gaps in Evidence (See 2.4.1)
2.4.3	Orient Government Agencies and Partners on Using Evidence in SBCC Programming
2.4.4	Facilitate National Communication Channels Assessment to Map Existing Approaches and Effectiveness, Selecting Key Channels/Approaches (e.g., Radio, Mobile, TV, Community Engagement)
2.4.5	Based on Assessment, Invest in Select Communication Channels for Health Promotion (See 2.4.4)

SO 2.5: Develop and Launch a National Health Promotion Campaign

Currently, no consistent or sustained national health promotion campaigns are taking place in the country. There are occasional event-based days, usually driven by recognition of UN days. Sierra Leone needs a broader, well-planned and coalition-based platform from which to address public health. Those participating in May 2016 stakeholder consultations felt it was time to develop a plan for such a sustained campaign. One feature of such a campaign, for example, might be a national logo and/or slogan to symbolize health that can be adopted by the MOHS and all of its partners.

Major activities for this SO:

2.5.1	Develop a National Health Promotion Campaign that Includes a National Logo
2.5.2	Hold National- and District-level Campaign Launches
2.5.3	Roll Out National Campaign (e.g., Broadcast, Print Distribution)
2.5.4	Monitor and Evaluate National Campaign Outcomes

SO 2.6: Facilitate Development of an Emergency Communication Plan

Given Sierra Leone's recent history, its ability to respond to public health emergencies, such as disease outbreaks, must be central to its national health promotion strategy. Indeed, this component of the Strategy is so important that the MOHS has dedicated a separate volume to elaborate on its emergency communication strategy. A brief mention of that component of national health promotion efforts is included here to make the point that pursuing that agenda represents one of the nine key areas for common action in health promotion in the country.

Some features of the public health emergency response system will include:

- a continued emphasis on coordinating committees and taskforces at all levels;
- capacity building in emergency and risk communication;
- a use of media that has already proven effective, such as a toll free hotline, use of SMS messages, radio programming in local dialects and mobile PA systems;
- an expansion of community surveillance efforts;
- community engagement, group discussions, drama groups and local celebrities; and
- continued use of community bye-laws to create the enabling environment for action.

Major activities include:

2.6.1	Contribute to Emergency Communication Plan and Training Curriculum
2.6.2	Support Emergency Communication Training at District-level

SO 2.7: Strengthen Integration of Health Promotion Activities with Activities in Other Sectors – e.g., Education, Agriculture, Youth – to Achieve Health and Development Gains

It will be important for the HED to explore deepening the integration of public health promotion within the broader national development agenda. Benefits of a more integrated approach could include improving community ownership and satisfaction, reach, equity, sustainability, operations, value for money and impact.

Below are just a few of the opportunities that could be further explored:

- Linking family planning with promoting girls' empowerment and education issues through the Ministry of Education, Science and Technology
- Reaching women and children with health promotion activities through the Ministry of Social Welfare, Gender and Children's Affairs
- Exploring or strengthening integrated nutrition programming with the Ministry of Agriculture, Food Security and Forestry
- Strengthening coordination of health messages with the Ministry of Youth Affairs
- Coordinating health promotion activities and messages with sports celebrities and activities through the Ministry of Sports
- Strengthening relationships with the Ministry of Information and Communication to attain greater press access and information services

- Strengthening partnerships with the Ministry of Local Governments and Rural Development and the Ministry of Internal Affairs, Local Government and Rural Affairs to gain access to and influence regional- and local-level leaders

The immediate aim of this SO is to identify mutual benefits of integrating health promotion with other government development areas where it makes sense. An assessment of the costs and benefits of this approach in Sierra Leone will be an important first step toward this end. Other agenda items can include roles/responsibilities related to integration efforts, support needs to operationalize integration and appointing health promotion point people for each collaborating Ministry. Stakeholders will meet regularly to review progress on health promotion activities and identify and address problems.

Major activities include:

2.7.1	Convene Multi-stakeholder Meetings with Relevant Ministries to Integrate Health Promotion
2.7.2	Assign HP Role (e.g., Seconded, Focal Point) to Support HP Activities in Four Ministries (e.g., Education, Agriculture, Youth, Gender)

SO 2.8 Launch in Full Effect a National Public Health Information Line

This SO aims to equip HED and the national SM Pillar with an additional tool that is readily available as a channel for public interaction and communication. The aim is to strengthen nationwide strategies, which can benefit from one-on-one interaction with individuals within a framework for behaviour change modification. A sustainable public health line has proven effective and useful in connecting targeted demographics (such as teenagers and pregnant and lactating mothers, etc.) with the information they need. The public will be encouraged to call into a public health line at any point in time and access health information at no cost.

A call centre tool also provides a platform for easy analytics on health promotion activities and its impact on public awareness. The number of health information calls received can be tagged as directly proportional to the increase or decrease in public knowledge about key public health issues and the options they have to prevent and resolve them.

Major activities include:

2.8.1	Conduct Resource Mobilization Activities and Secure Funding from Stakeholders
2.8.2	Set-up a Toll-free Hotline Number or Repurpose an Existing Line, such as the Ministry of Health's 117
2.8.3	Conduct Activities to Educate the Public on Using the Public Health Line
2.8.4	Integrate the Call Centre Approach to Health Promotion in all MOHS Strategic Plans as Part of Strengthening a Continuous National level Method of Health Promotion
2.8.5	Conduct Trainings for Call Centre Health Promotion and Information with Staff

OBJECTIVE 3. IMPROVEHUMAN RESOURCES AND CAPACITY STRENGTHENING FOR HEALTH PROMOTION

The constraints on human resources for health promotion in Sierra Leone are a major barrier to the implementation of consistently high-quality programming at the scale that is required. While these constraints cannot be fully addressed in one five-year strategy, the MOHS can establish a foundation for health promotion human resources – including for logistical support – on which future programmes can build. Broadly, approaches in this area will fall into two categories of action: **training** and **workforce policy**.

SO 3.1: Develop Training Programme for Pre-service and In-service Health Promotion Professionals

The development of **pre-service training** partnerships with one or more postgraduate training colleges is a particular priority for this Strategy. Three possibilities for exploration include University of Makeni (UNIMAK), a private Catholic university, the College of Medicine and Allied Health Sciences (COMAHS) and the Postgraduate Training institution the MOHS is planning.

The priority **beneficiaries** of health promotion capacity strengthening should be:

- At the **national level**, HED staff (including those seconded to Disease Prevention and Control and Malaria Control) and the national SM Pillar members
- At the **district level**, the district SM coordinators, the DHMT members, the members of the SM committee and relevant government ministries department and agencies
- At the **community level**, local council and VDC members and influential members of secret societies

Capacity strengthening work will be guided by the understanding that learners, particularly adult learners, exhibit various learning styles. So to be effective, efforts to build human resources will interact with those learners through a **blended learning approach** that mixes methods:

- **Providing face-to-face and virtual learning opportunities** through experiential/workplace learning programmes, mentoring and coaching relationships and embedded advisors
- **Facilitating access to and encouraging uptake and application of resources** by providing job aids and resources, connecting to external resources including and developing resources, case studies and best practices
- **Facilitating participation in learning and exchange events** such as internships or professional exchange opportunities; TWGs/SBCC communities of practice; formal learning programmes including provision of scholarships; and conferences and meetings

As a priority for this Strategy, the HED will develop a health promotion pre-service training programme with one or more local training institutions, and tailor that training programme to develop specific competencies required by public and voluntary sector employers. In-service training curricula will also be developed so methods, participants and activities are planned and comprehensive. For example, it might include a basic programme on health promotion principles and practices and brief refreshers on technical areas such as health topics, risk communication, use of media and use of data, all rolled out through an annual nationwide plan.

Major activities for this SO:

3.1.1	Develop National Training Plan of In-service Training Opportunities for HP Professionals
3.1.2	Assign HED Staff to Attend International Health Conference (e.g., ASTMH, SBCC Conference) and Health Communication Study Tour (e.g., WHO)
3.1.3	Hold at Least One HP-focused Capacity Building TOT Per Year for HED and Partners at National/District Level (e.g., DSMCs) – As Per Training Plan (3.1.1)
3.1.4	Hold a Strategic Health Communication Training in Sierra Leone (Repeated Every Three Years) – As Per Training Plan (3.1.1)
3.1.5	For Pre-service Training, Assess and Finalize Potential Partnership with Training Institution(s)
3.1.6	Develop Curriculum with Selected Training Institution(s)
3.1.7	Provide Annual General Support to Institution to Implement Training, (e.g., Support for Faculty, Materials)

SO 3.2: Review and Update Human Resources for Health Policy to Include Health Promotion

In addition to capacity building, the Strategy will also collaborate with the office of the Chief Medical Officer (CMO)and the Human Resources Directorate of the MOHS to clarify and elevate the standing of the health promotion function within the health sector hierarchy by:

- clarifying the career path of health promotion practitioners;
- placing a greater number of specialists in full time dedicated positions;
- providing input to and endorsing the final form of the pre-service and in-service training strategies;
- clarifying job descriptions and remuneration packages for all necessary Health Promotion functions, both at national and district levels; and
- in concert with the *Advocacy for Strengthened Health Promotion* component of this Strategy, advocating for increased resources to fund improved health promotion human resources.

The priorities for this SO are advocating for the strengthening of the HED workforce and meeting with the MOHS Human Resources for Health to review policy to ensure it leads to a strengthened workforce for HED.

Major activities for this SO:

3.2.1	Update and Clarify HP Roles/Responsibilities, Terms of Service and Professional Development to Guide MOHS Leadership (Annually)
3.2.2	Advocate with MOHS Human Resources for Health and Partners to Influence Strengthening the HED Workforce

OBJECTIVE 4. RAISE AWARENESS AND MOBILIZE RESOURCES FOR STRENGTHENED HEALTH PROMOTION

To shift the norm away from being the "spare tyre" in the health system, the HED will develop a series of advocacy activities so that new and higher expectations of the HED and health promotion activities can take root. Ultimately, the aim will be to create opportunities to influence key public and private sector decision-makers to increase resources to support the HED and health promotion interventions.

A number of implementing partners have a strong experience in advocacy – such as Health for All, Save the Children, Mama Ye, World Vision and Inter-Religious Council – and will, along with other partners, be called on to support the HED to achieve this objective.

SO 4.1: Advocate for Increased Funding, Operational Support and Human Resources for Health Promotion Activities

Health promotion contributes to core performance indicators by addressing knowledge, attitudes and efficacy, encouraging care-seeking positive health behaviours and removing barriers to practicing them.

The priority for this SO amounts to ensuring the HED and partners are speaking with one voice to raise the visibility of health promotion to government decision-makers, the private sector and donors. Key government decision-makers include, but are not limited to, Parliamentary Health Committee, Minister of Finance and Economic Development, Minister of Health and Sanitation, CMO and district councils. It will be critical for the HED to have a technical advisor working with them to help lead these efforts and equip partners with the evidence, messages and materials they need to encourage investments in health promotion. Talking points will articulate the message that investing in health promotion leads to healthier populations and supports the priority health systems strengthening efforts stated in the MOHS' recovery plans.[6]

Recruiting influential health promotion champions – such as donor organizations and business leaders – and gaining media attention on the impact of health promotion will be key.

Major activities for this SO:

4.1.1	Develop Advocacy Plan to Identify Objectives, Key Audiences, Messages and Opportunities to Raise the Profile of HP and Mobilize Resources
4.1.2	Develop and Disseminate Evidence Briefs on Impact and Importance of HP in Sierra Leone
4.1.3	Hold Training for Journalists to Orient Press on Covering Health Promotion Stories
4.1.4	Hold National Event to Launch Evidence Briefs and Raise Visibility of Health Promotion
4.1.5	Orient District-level Decision-makers (e.g., District Council, VDCs, FMCs/HMCs) on Impact of HP via Advocacy "Road Shows"
4.1.6	Hold Advocacy Meeting with Parliamentary Health Committee to Showcase HP Successes and Advocate for Increased Funding for Health Promotion

[6] According to the MOFED's 2016 budget speech, priorities for the country highlight key areas of the Ebola recovery strategy and the Sustainable Development Goals (SDGs). It will be important for advocates to draw on these priorities in their advocacy messages.

SO 4.2: Recruit at Least Five New Private Sector Institutions to Invest in National Health Promotion Activities

Advocating for increased resources from the government alone will not be enough. The MOHS HED will look toward additional private sector funding to help support health promotion activities and fill critical operational gaps. This means offering a menu of options for the private sector to support, including printing, dissemination, volunteer employee mobilizers, events and other options. Options will also include radio, TV or billboard advertising for the national health campaign (see SO 2.5) that the private sector will want to get behind and sponsor. Social events with celebrities will make joining this initiative more desirable, and business leaders will have opportunities to meet and be photographed at health promotion events. Activities within this SO will provide national visibility to private sector partners and help foster a norm of investing in health. Private sector leaders are also perfectly situated to ensure the government is investing its own resources in promoting health.

Major activities for this SO:

4.2.1	Develop Private Sector Brochure Outlining Options for Investing in HP in Sierra Leone, with a Business Case for Investing in HP
4.2.2	Hold Annual Business Networking Forums to Encourage Investments in Health Promotion

OBJECTIVE 5. IMPROVE MONITORING AND EVALUATION SYSTEMS FOR HEALTH PROMOTION

M&E allows for an in-depth understanding of the impact that health communication initiatives have on people's attitudes, behaviours and other psychosocial factors, which ultimately affect health outcomes. Having a solid evidence base on health promotion activities in the country will not only inform the MOHS and partners of what approaches and messages are working and which are not, but will also build a case for the importance of health promotion to overall national health priorities.

A priority of this objective will be to develop a standard M&E framework for both the management and implementation of health promotion activities. This framework will be used at the national, district and community levels.

For example, data collection will be standardized to allow for monitoring of inputs, outputs and the reach of health promotion activities, considering elements such as the socio-demographic characteristics of people reached, audience reactions and feedback to health promotion interventions and positive trends in behaviour change, where possible.

Importantly, in collaboration with the Directorate of Policy, Planning and Information (DPPI), the HED will receive M&E support and training, strengthen indicators for health promotion and ensure indicators are aligned with overall national health indicators. See attached **Annex B** for a description of methods, indicators and targets that will be used to assess the implementation of this Strategy as well as health promotion's impact on key public health indicators.

To support this effort, the HED will establishan M&E subcommittee within the SM Pillar, linking it to the existing MOHS M&E TWG, when appropriate, to address data on knowledge, attitudes, practices and behaviours, and to facilitate the sharing of data and resources and the use of existing data and surveys for making decisions.

Major activities for this objective:

5.1.1	Hold Stakeholder Meeting to Agree on HP Monitoring Indicators and M&E Priorities for HP
5.1.2	Create M&E Subcommittee with a TOR within the SM Pillar, and Facilitate the Incorporation of M&E in the Implementation of All Health Promotion Activities
5.1.3	Identify an HP Staff Person to Focus on M&E and Represent HED in M&E Steering Committee Meetings
5.1.4	Develop M&E Framework with DPPI and Partner Support
5.1.5	Review and Incorporate Behavioral Indicators into Existing Monitoring Systems, e.g., the Health Management Information System (HMIS)
5.1.6	Ensure HP M&E Framework Is Included in MOHS M&E Trainings to Districts

OBJECTIVE 6. STRENGTHEN KNOWLEDGE SHARING AND MANAGEMENT

Functioning knowledge management systems are crucial to the success of this Strategy and the impact of national health promotion activities. It is essential that the HED has a strong documentation, filing and sharing system.

Broadly speaking, beginning with the simplest and highest priority and continuing to the more complex later priorities, the following initiatives will be pursued over the life-span of this Strategy:

- Develop a functional library of health promotion materials and resources in a venue that is easily accessible to the widest array of programme partners
- Establish a consistent, long-term plan for meetings and events that can be used as opportunities for information exchange
- Create a health promotion newsletter to share information on tools, partners and programmes
- Establish standard, intuitive and consistently-applied electronic filing systems in directories accessible to a number of HED staff
- Create a system of health-promotion-related listservs for members of the health promotion and communication pillars to share information with each other

Given the relatively low access to internet connectivity, a priority for this Strategy will be to invest in improving internet access at the national and district level. In the meantime, face-to-face knowledge sharing systems are being emphasised. A functioning knowledge management system will share critical data, best practices, guidelines and other important documents to improve overall efficiency, coordination and leadership.

Major activities for this objective:

6.1.1	Develop a Knowledge Management Plan Based on 2016 Knowledge Management Assessment
6.1.2	Provide Technical Assistance to Districts to Implement Knowledge Management Plan
6.1.3	Ensure the HED and District SM Coordinators Have Internet Connectivity and an IT Person at the National Level
6.1.4	Organize Electronic Files at HED (Maintaining the Knowledge Gateway)
6.1.5	Organize Hardcopy Files at HED (Completing Filing System)
6.1.6	Create Tailored Email Listservs that Include Relevant Partners
6.1.7	Create Electronic and Hardcopy Versions of Health Promotion Newsletter Quarterly for Nationwide Distribution
6.1.8	Ensure HED Page is on MOHS Website, Linking to Knowledge Gateway
6.1.9	Hold Best Practices Exchange Semi-annually through SM Pillar Meeting

APPENDIX A. ADDITIONAL HEALTH LANDSCAPE IN SIERRA LEONE

This section provides additional information on the health landscape in Sierra Leone, as indicated in the *Situation Analysis*.

Immunizations

The number of children fully vaccinated by age 12 months increased in the five years between the 2008 DHS and 2013 DHS, from 31percent to 58percent, and more than half of children were fully vaccinated by the age of five years old. In addition, the number of children who received no vaccinations decreased to just 4percent in 2013. Reports about vaccination rates during the Ebola outbreak are conflicted, with some reporting rates declined due to vaccination campaigns being cancelled along with fear of becoming infected by Ebola either by the vaccines or by attending a facility (Takahashi et al., 2016). The drop in vaccination rates manifested in outbreaks of measles and other diseases (Patel, 2016), but toward the end of the Ebola epidemic, the children of Sierra Leone were again benefiting from mass vaccination campaigns. However, 19.7 percent of mothers are unaware that they need to bring children back to repeat immunizations (Expanded Programme on Immunization[EPI] Report, 2013). Further, 31.9 percent of mothers are not aware of the need to return for the tetanus vaccine (EPI Report, 2013).

Care-seeking Barriers

Many external and internal factors influence care-seeking practices, which are important to understand in order to increase utilization of services, such as:

- Infrastructure
  In Sierra Leone, the overall infrastructure of the health system is inadequate to serve the population's health needs, and the limited facilities that do exist are often under-staffed and lacking the proper equipment and supplies (Amnesty International, 2009; UNICEF, 2014).

- Transportation
  Another frequently cited barrier to seeking care is the challenge of going to a facility. Patients considering seeking care at a lower-level facility may be discouraged from even doing that due to the possibility of being referred for a higher level of care and then facing poor roads and long distances with potentially high costs for transportation (Amnesty International, 2009; Oyerinde et al., 2012).

- Financial
  Patients often have to pay out of pocket and on the spot for basic medical supplies and medicines (Amnesty International, 2009; Oyerinde et al., 2012). Two-thirds of respondents in the 2013 DHS identified having enough money for treatment as a barrier to accessing care.

Malaria

Malaria is the biggest health threat and leading cause of death in Sierra Leone, accounting for one quarter of deaths every year, which amounts to more deaths per year than during the entire Ebola outbreak (2013, DHS). Knowledge of malaria and that it is transmitted by mosquitos is high, but awareness about malaria prevention and treatment-seeking practices, particularly for young children and pregnant women, is lower.

The 2013 Malaria Indicator Survey (MIS) found that almost two-thirds of households own a mosquito net, with net ownership being more prevalent in rural areas compared to urban areas; however, very few (17 percent) households had an adequate number of nets (one for every two people) and living in a house with a mosquito net does not guarantee use (MIS 2014). Overall, pregnant women and children under five years are more likely than the general population to sleep under a mosquito net, but the incidence of malaria and malaria-related illness among these vulnerable groups indicates a greater need for further emphasis on sleeping under a net every night and intermittent preventative treatment in pregnancy (IPTp).According to the 2013 MIS, 53 percent of pregnant women and 55 percent of children under five do not sleep under an ITN.

When it comes to treatment of malaria in children, according to the 2013 DHS report, nearly two-thirds of children with a fever were taken to a health facility, provider or pharmacy for treatment. Of those children taken to a facility with a fever, 37 percent took artemisin in-based combination therapies (ACTs) for treatment, with most of them taking an ACT within 24 hours of the onset of their fever (DHS 2013). Unfortunately, according to UNICEF (2014), the number of children under five years treated for malaria fell 39 percent during the Ebola epidemic. A number of other studies and experts have expressed concern about the full extent of the impact of the Ebola outbreak on malaria in Sierra Leone, with predictions of a significant rise in the number of cases and a decline in treatment seeking.

HIV/AIDS

The HIV prevalence rate in Sierra Leone has remained stable (at 1.5 percent) for about a decade, and the country has made significant strides in testing, prevention and treatment, especially among key populations and vulnerable populations such as pregnant women; however, much work remains to be done to reach the national goals of zero new infections and zero AIDS-related deaths.

Awareness of HIV/AIDS in the general population is nearly universal and most people are aware of a place they could be tested for HIV, but only 38 percent of women and 14 percent of men reported in the 2013 DHS that they had ever been tested for HIV and received their results. Further, 75 percent of women and 69 percent of men do not have comprehensive knowledge on HIV AIDS prevention and transmission (DHS, 2013). Even among pregnant women, a vulnerable population, rates of testing remain low, with nearly two-thirds of pregnant women receiving HIV counseling during an ANC visit, but only 43 percent being tested for HIV (2013 DHS). Despite low levels of testing among pregnant women, there is very high coverage of prevention of mother-to-child transmission (PMTCT). In the general population, ART coverage has increased in recent years, yet it remains low among adults at 39 percent.

Commercial sex workers and their clients contribute to 40 percent of new HIV infections, so there has been a major focus on this population. Just between 2013 and 2014, a significant increase was seen in the percentage of sex workers who had been tested for HIV within the past 12 months and those who reported using a condom with their most recent client (UNAIDS, 2014); however, the Ebola outbreak hindered the national AIDS response as resources previously dedicated to HIV prevention and treatment were redirected to the Ebola epidemic. In addition, with fear of contracting Ebola keeping people from going to health facilities, the number of people being tested and treated for HIV undoubtedly decreased.

Tuberculosis

Very limited data is publicly available about tuberculosis (TB) in Sierra Leone, including precise figures about the current incidence rate of TB; however, recent statistics indicate that TB remains a significant health issue in Sierra Leone. Between 2004 and 2007 the number of registered cases almost doubled, although during that same period the detection rate also increased slightly (MOHS, 2010). The TB treatment success rate did increase between 2000 and 2009, but in 2010 it dropped to the level it was in 2000 (79 percent) (MOHS, 2010). This could have been simply an anomaly or an indication of a larger issue, including possibly being related to the emergence of multi-drug resistant TB (WHO, 2015).

No data or reports were located which address the effect of the Ebola outbreak on TB, yet given the closure of facilities and diversion of resources to the Ebola crisis, it is likely that the situation related to TB worsened during the Ebola outbreak.

Diarrhea

The prevalence of diarrhoea went down from 15 per cent in 2010 (MICS) to 11 percent in 2013 (DHS). As is the case in many other developing countries, however, diarrhoea is still a leading cause of death among children in Sierra Leone, accounting for 12percentof the deaths of children under five years old (Liu et al., 2012). A combination of not seeking treatment at a facility and low knowledge of home treatment measures increases the danger of diarrhoea for children in Sierra Leone.

Reports have revealed varying levels of knowledge of causes of and appropriate courses of action for diarrhea. Studies in Sierra Leone have found that people often correctly identify the cause of diarrhea as poor hygiene conditions and practices, but when probed, respondents also identified other causes, some of which were rooted in myths and superstitions (Kanu et al., 2014; McMahon et al., 2013). In terms of treatment, 15 percent of children with diarrhea had not been treated with oral rehydration salts (ORS).Furthermore, the 2013 DHS revealed inappropriate home treatment measures, with four in 10children with a diarrhea episode given less to drink and six in 10children given less or no food. This combination of not seeking treatment at a facility and low knowledge of home treatment measures increases the danger of diarrhea for children in Sierra Leone.

Childhood Nutrition

The prevalence of global acute malnutrition decreased from 9.6 percent for boys and 7.4 per cent for girls in 2010 (MICS) to 5.7 per cent for boys and 3.8 percent for girls in 2014 (Sierra Leone National Nutrition Survey, 2014). The 2014 Sierra Leone National Nutrition Survey further states that little more than one quarter of all children under five years of age are stunted in Sierra Leone (28.8 percent with a higher percentage of boys [32 percent] than in girls [25 percent]), showing a slight improvement since the 2013 DHS,[7] but suggesting that children in Sierra Leone are still not being properly nourished. Another indication of poor childhood nutrition is that four out of five children are anemic, with over half of those being moderately or severely anemic (DHS, 2013). In addition, 41 percent of children up to six months of age are not exclusively breastfed and 63.6 percent of children under two years of age do not have the minimum dietary diversity (SMART Survey 2014). Moreover, according to UNICEF, more than half of children under age two are not appropriately fed with complementary foods and a majority are not getting a variety of foods often enough (UNICEF Sierra Leone).

[7]According to the 2013 DHS report, only seven percent of babies were considered to have a low birth weight; however, for children under five years old 38 percent were stunted and 16 percent were underweight.

In addition to improper feeding practices, malnutrition among children who are breastfeeding also is affected by the mother's size and her likely nutritional status. The 2013 DHS found that if a mother's body mass index (BMI) was considered to be in the range of thin or underweight, her child was more likely to be underweight than mothers with higher BMIs. In Sierra Leone, just over half of infants were breastfed within the first hour of birth. A study by Save the Children (2012) revealed the belief that water, not breastmilk, should be the first meal for a newborn, and the same study also found that mothers typically thought that colostrum was bad and should be discarded.

Prior to the Ebola outbreak the government recognized the promotion of exclusive breastfeeding as a priority and was also working on adopting a Code on Marketing of Breast Milk Substitutes to reduce the amount of promotion of breast milk substitutes and encourage breastfeeding.

Water, Sanitation and Hygiene

Steady progress has been made in improving water and sanitation conditions in Sierra Leone, leading to the 2013 DHS report finding that three out of five households obtain drinking water from an improved source. Unfortunately, there is a significant urban-rural disparity (89 percent compared to 48 percent of households). Only ten percent of households use an improved, unshared toilet facility, and again there is a significant urban-rural disparity (20 percent compared to five percent). In households where a place for hand washing was observed, nearly half had no water, soap or other cleaning agent (2013 DHS), but with the focus on hand washing and hygiene during the Ebola outbreak it is likely that more households are practicing proper hygiene behaviours. Further, 60 percent of households do not wash hands after cleaning a child who defecated, and 14 percent of households do not wash hands after defecating (SLNNS, 2014). Handwashing areas were observed in 22 percent of households (DHS, 2013).

Gender-based Violence and Domestic Violence

Gender-based violence, including forced marriage and rape, was widespread during Sierra Leone's civil war, and unfortunately remains commonplace in the post-conflict context with more than half of women having experienced physical violence and 11percentexperiencing sexual violence at some point in their adult lives (2013, DHS). In addition to domestic violence, females in Sierra Leone are subject to gender-based violence at young ages through female genital mutilation (FGM), early marriage, rape and school-related sexual abuse. According to the 2013 DHS, nine out of ten women have experienced some form of circumcision. Furthermore, girls reported that they faced a greater risk of sexual exploitation or assault during the Ebola outbreak. Other girls reported that some girls turned to transactional sex to support themselves after their family members lost their lives to Ebola (Risso-Gill & Finnegan, 2015).

Non-communicable Diseases

Information on non-communicable diseases (NCDs) in Sierra Leone is scarce. The little that is known points to NCDs such as cardiovascular diseases, cancers and diabetes being health issues needing more attention. According to the WHO (2015), NCDs accounted for around one quarter of deaths in Sierra Leone, with cardiovascular diseases being the most common NCD cause of death.

Women's Participation in Decision Making

Examining women's participation in making decisions about their family's health care reveals that women in Sierra Leone have very limited autonomy. Tellingly, even when it comes to their own

healthcare, only one in 10women can make a decision on their own, without consulting anyone else (2013, DHS). For the healthcare of children, women typically share decision-making authority but play a more prominent role. According to a recent study (Wittels, 2016), this greater role for women is due to their ability to identify symptoms and act quickly in emergencies because they spend more time with the children.

Influences on Healthcare Decision Making and Care-seeking

- Trust in Services and Providers
  A recent study (Wittels, 2016) found that people typically trust health workers to provide information on health, but when it comes to providing services that improve health conditions, people have more doubt in the personal and medical treatment provided by nurses and doctors. There are indications that trust in the health system diminished due to rumours and misconceptions about the role of health facilities and providers in the outbreak.

- Family Involvement
  Male involvement can motivate women to seek services at facilities and, as such, men can be an important catalyst for improved care-seeking practices. Female relatives and friends can also have a strong influence on health decisions and care-seeking. Generally, Sierra Leoneans also turn to friends and relatives who have experience with the problem (Wittels, 2016).

APPENDIX B. REVIEW OF NATIONAL POLICY AND GUIDANCE

Below is a very brief summary of the key points made in the 2010 Policy, and the participants' observations.

Leadership for Coordination and Impact

- **This section of the 2010 Policy called for** the establishment of a Health Promotion Directorate; using the term "Health Promotion" rather than "Health Education"; re-examining the qualifications, staffing and professional progression of health promotion staff; and ensuring adequate health promotion funding.
- Participants in the May 2016 review discussion felt that, while there had been some progress made on the staffing issue, there was still substantial work to do. Funding remains inadequate and budgets need to be drafted for local council consideration.

Implementation Plan

- **This section of the 2010 Policy called for** the establishment of district health promotion units; health promotion becoming a core function of all ministries/departments; broadened health promotion partnerships; health promotion becoming central to development agenda; and coordination in materials development.
- Participants in the May 2016 review discussion felt that materials development was well coordinated during the Ebola outbreak response. Materials were presented to the SM subcommittee and vetted. During the Ebola response, the district SM committees and their coordinators also helped coordinate materials development and distribution and other SM activities. However, the district SM committees are not as structured as they would like them to be. For example, some districts do not have an office for their SM coordinator. In addition, there is more work to do to position health promotion across the development agenda in various ministries. Some progress was made during the Ebola response, and some efforts made to link health promotion in agriculture and social welfare, but more work is needed to ensure it is truly crosscutting.

Capacity Building

- **This section of the 2010 Policy called for** multiple channels of instruction to build health promotion skills; a health promotion "human resource development plan" to promote career opportunities; training opportunities at degree level, including fellowships/scholarships; pre-service training programmes with public and private universities within Sierra Leone; and continuing education workshops, seminars and conferences.
- Participants in the May 2016 review discussion felt people were eager for capacity building opportunities, but those options were not available. While occasional as-needed continuing education workshops do take place, there are no formal plans or annual strategies outlining minimum offerings. Fellowships are hard to come by. Although specific technical courses may not be available, some general public health trainings are available, including a bachelor degree programme that will soon start at the University of Makeni.

Health Promotion Practice

- **This section of the 2010 Policy called for** use of participation and empowerment approaches; mainstreaming health promotion across development sectors; broadening partnerships (civil society, academic, public and private sectors); using local/preferred languages with beneficiaries; strengthening health promotion skills; sustainable financing through government budget; and documenting and sharing evidence of effectiveness.
- Participants in the May 2016 review discussion felt some progress has been made on this agenda: partnerships for health promotion are expanding; most radio programming and some print materials are available in local languages; and participation and empowerment through district social mobilizers, CHWs, women's groups and religious and traditional leaders is improved. WHO and UNICEF have also supplemented the district health education structures.

Priority Public Health Issues

- **This section of the 2010 Policy called for** an integrated approach to disease based on primary health care principles; addressing inequities and inequalities; addressing new threats (e.g., Avian Influenza [AI], Swine Flu [H1N1], disasters and urbanization); and population-specific health promotion.
- Participants in the May 2016 review discussion felt this agenda had been partially accomplished, but substantial work still remains.

Policy for Healthy Settings

- **This section of the 2010 Policy called for** health promotion at all levels of the health care system; implementation of the Health Promoting School Concept or Child Friendly Schools; educating parents on communicable and non-communicable health issues; integrating health promotion; and preventing harmful products in recreational settings.
- Participants in the May 2016 review discussion felt some progress had been made on this agenda, particularly with some parental education and school-based programming, but much work still remains.

Health Communication

- **This section of the 2010 Policy states that health communication should** involve both public and private mass media; emphasise radio; utilize various interpersonal approaches; include locally produced print materials; and include beneficiary involvement in media/material development.
- Participants in the May 2016 review discussion felt those goals were partially accomplished. Health promotion staff have developed a healthy collaboration with a network of newspapers and radio stations. While some printing is done outside of Sierra Leone, most materials are locally developed and produced. Generally, beneficiaries are involved in media and programme development. For instance, Sight Savers did a good job involving beneficiaries in recent eye care work. However, beneficiary involvement is not done consistently or thoroughly. Participants felt there was much more that could be done to encourage the use of social media, which is very popular among young people.

Building Healthy Public Policies

- **This section of the 2010 Policy states that** health promotion should be integrated into all Government of Sierra Leone policies; a national advocacy committee for health promotion should be established; programmes should focus on reducing the health equity gap; health promotion should address risk factors and social determinants of health; Sierra Leone should use regulations and legislation as a health promotion tool; and the health sector should partner widely.
- Participants in the May 2016 review discussion felt some progress had been made building healthy public policies. Perhaps the best evidence was the use of district-level bye-laws during the Ebola outbreak. Sierra Leone also has a national tobacco control taskforce, and tobacco control legislation was in progress at the time of the review. District-level bye-laws have also been used to support bed net distribution and use and address gender-based violence. Sierra Leone has seen a reduction in home deliveries and the Free Health Care Initiative (FHCI) has helped to reduce the health care equity gap. But more can be done in the policy domain related to risk factors, such as during pregnancy, and to address drug and alcohol use among youth.

Supportive Structures for Health Promotion

- **This section of the 2010 Policy states that MOHS should establish** an Advisory Council to a Health Promotion Directorate; local health committees at district and community levels with a "functioning multisectoral health promotion team"; health information centres in collaboration with the National Library and various Ministries; an intersectoral task force on health promotion; a Sierra Leone Health Promotion Network; a Sierra Leone health promotion association; and a Sierra Leone health promotion society. The Directorate should work with all NGOs and development partners involved in health promotion.
- Participants in the May 2016 review discussion felt some accomplishments had been achieved in developing these supportive structures. For example, during the Ebola outbreak, the Social Mobilization and Advocacy Consortium (SMAC) was a good example of intersectoral collaboration and partnership with NGOs. District SM committees and local health committees are generally established. The national SM pillar is intersectoral.

Financing Health Promotion

- **This section of the 2010 policy called for** increased government allocations to health promotion across all Government of Sierra Leone Ministries and Departments; adequate funding of the Health Promotion Directorate by MOHS; the government to tax harmful products, and establish a health promotion foundation to programme that revenue; partner with private sector, civil society and international organizations to mobilize more resources for health promotion; and the Health Promotion Directorate to be characterized by transparency, accountability and efficiency.
- Participants all agreed that significant progress still needs to be made at all levels on the health promotion financing agenda.

Monitoring

- **This section of the 2010 Policy called for** a national consultation to assess progress and monitor policy implementation; the development of guidelines to monitor policy progress

including indicators and targets; documentation and sharing of monitoring findings; and revisions to the 2010 Policy based on findings

- Participants in the May 2016 review discussion felt some investments had been made in health promotion M&E by individual programmes and donors, but work remains to be done to put in place a national health promotion monitoring system.

APPENDIX C. PRIORITIZED HEALTH PROMOTION NEEDS ACROSS MOHS UNITS

During consultations, a number of MOHS directorates and programmes have identified their strategic priorities for health promotion for 2017-2021. By addressing these priorities first, the MOHS will likely achieve the biggest impact on health outcomes in the immediate term, and reinforce the value of health promotion to the various units of the Ministry. These priorities are included below.

Directorate of Food and Nutrition: Includes maternal infant and young child nutrition (MIYCN), integrated management of acute malnutrition (IMAM), micronutrients, clinical nutrition and nutrition surveillance and research.

- **Priority Areas for Health Promotion:** According to the Directorate, the priority health promotion issue to address focuses on misuse of ready-to-use therapeutic foods by health workers and community members (e.g., selling the foods in the market and not providing them to the malnourished children). The Directorate found high rates of misuse across the country. Ready-to-use therapeutic food (RUTF) is for children from six to 59 months old who are severely malnourished. Another priority is preventative behaviours, such as promoting growing and eating nutritious foods, especially for pregnant women and children under five.

Directorate of Primary Health Care (DPHC): Supports interventions focusing on CHWs and health promotion, including supervising and monitoring CHWs.

- **Priority Areas for Health Promotion**: With more than 20 catchment communities, the number one priority for the DPHC is ensuring CHWs are recognized for playing a key role in promoting health in communities and conducting community-based surveillance. The CHW Hub is represented in each DHMT. The DPHC is working with NGO partners in all the districts and is appealing to all partners to work with them and the CHWs.

Directorate of Reproductive and Child Health: Includes the Child Health/Expanded Programme on Immunization (EPI), the Reproductive Health and Family Planning Program and the School and Adolescent Health Program. Each programme has technical and support staff.

- **Priority Areas for Health Promotion**: The top priority is reducing teenage pregnancy, which is the third highest cause for school dropouts. According to the Secretariat for Teenage Pregnancy and as stated earlier, 8 percent of teenagers are impregnated by peers, 35 percent by men 10 years older than them (DHS, 2008). Other priorities include reducing fistula, reducing unsafe abortions and discouraging child marriage.

Directorate of Disease Prevention and Control: Includes the following programmes: National Malaria Control Programme (NMCP); National HIV/AIDS Control Programme (NACP); Maternal and Child Health (MCH)/EPI Programme (links to NMCP and NACP); TB/Leprosy Control Programme; Neglected Tropical Diseases Programme; and Disease Surveillance.

- **Priority Areas for Health Promotion:** Priority health promotion issues for the NMCP is increasing bed net usage, especially among pregnant women and children under five, and to use the bed nets all year round, not just during the rainy season. Relatedly, a priority is also to discourage the misuse of bed nets (e.g., using them for fishing). The second priority is to encourage pregnant women to go to ANC for intermittent preventative treatment in pregnancy with

sulfadoxine-pyrimethamine (IPTp-SP). For the Expanded Programme on Immunization (EPI) programme, the priority is to use messages to promote getting routine immunizations – which are more sustainable than regularly scheduled mass immunization campaigns – in nearby facilities in order to increase uptake. CHWs need training so they can encourage community members go for routine immunizations, especially now that a second dose of the measles vaccine is required. Another priority is increasing usage of the under five cards, which should be seen as a "passport" to enter school.

Directorate of Non-Communicable Diseases: In 2013, with support from the WHO, the Directorate launched its National NCDs Policy and Strategic Plan 2013–2017. The Directorate noted that the four major NCDs are cardiovascular diseases, cancers, chronic respiratory diseases and diabetes.

- **Priority Areas for Health Promotion:** During the launch of the 2013-2017 plan, the Directorate highlighted four behavioural risk factors for NCDs: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol.

APPENDIX D. BUDGET FOR NATIONAL HEALTH PROMOTION STRATEGY (2017-2021)

		Year 1				Year 2	Year 3	Year 4	Year 5	Total
		Q1	Q2	Q3	Q4					
IMPLEMENTATION PHASE										
0.1	Launch the Health Promotion Strategy	6,000	-	-	-	-	-	-	-	6,000
0.2	Orient District Teams on the Health Promotion Strategy	-	3,000	-	-	-	-	-	-	3,000
0.3	Meet with at Least 10 Partners/Donors to Secure Commitments to Support Individual Activities	200	-	-	-	-	-	-	-	200
0.4	Develop Detailed TOR for Proposed Technical Advisor	-	-	-	-	-	-	-	-	-
0.5	Recruit Technical Advisor to Support the HED	-	10,000	10,000	10,000	40,000	40,000	40,000	40,000	190,000
	Subtotal	-	6,200	13,000	10,000	10,000	40,000	40,000	40,000	199,200
	Inception Phase Total	-	6,200	13,000	10,000	10,000	40,000	40,000	40,000	199,200
OBJECTIVE 1: STRENGTHEN HEALTH PROMOTION STRUCTURES										
SO 1.1: Rejuvenate the Social Mobilization and Communication Pillars at National Level and Strengthen Coordination Mechanisms										
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
1.1.1	Review, Update and Disseminate SM Pillar TOR	-	-	-	-	-	-	-	-	-
1.1.2	Support the Finalization and Dissemination of the Communications Pillar TOR	-	-	-	-	-	-	-	-	-
1.1.3	Hold Monthly (More as Necessary) National SM Pillar Meetings	150	150	150	150	600	600	600	600	3,000
1.1.4	Hold National Communications Pillar Meetings (PHNEOC) Every Two Weeks	150	150	150	150	600	600	600	600	3,000
1.1.5	Participate in Inter-Pillar Meetings at National Level Called by PHNEOC for Improved Coordination	-	-	-	-	-	-	-	-	-
1.1.6	Conduct Periodic Capacity Assessment for Strengthening	-	-	-	-	500	-	500	-	1,000

	National SM Pillar and Provide Support									
	Subtotal	**300**	**300**	**300**	**300**	**1,700**	**1,200**	**1,700**	**1,200**	**7,000**
SO 1.2: Rejuvenate the Social Mobilization Pillar at District Level and Strengthen Coordination Mechanisms										
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
1.2.1	Review, Update and Disseminate District Level SM Pillar TOR	-	-	-	-	-	-	-	-	-
1.2.2	Map Active SM Pillar Partners and Identify Dormant SM Pillars	-	-	5,330	-	-	-	-	-	5,330
1.2.3	Hold a Revitalization Meeting to Present Mapping Landscape with Recommendations, TOR and Roles/Responsibilities	-	-	-	1,000	-	-	-	-	1,000
1.2.4	Conduct Two-day Capacity Assessment Meetings and Support (e.g., Training) for all District SM Pillars	-	-	-	30,000	-	30,000	-	-	60,000
1.2.5	Hold Monthly District-level SM Pillar Meetings (More Frequently as Needed) and Circulate Meeting Minutes	100	100	100	100	400	400	400	400	2,000
1.2.6	Attend Monthly District Coordination Meetings in person and include HP on the agenda, while serving as health advocates	-	-	-	-	-	-	-	-	-
1.2.7	Map and Develop MOUs with Functional Community Radio Stations in Each District for Message Dissemination	-	500	500	-	-	-	-	-	1,000
	Subtotal	**100**	**100**	**5,930**	**31,100**	**400**	**30,400**	**400**	**400**	**68,830**
SO 1.3: Strengthen Community-level Actors and Foster Community Ownership of Health										
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					

1.3.1	Develop and Disseminate Guidance on HP Roles and Responsibilities for Community Structures (e.g., VDCs, HMCs/FMCs, CHWs, Community Groups, etc.)	-	45,000	20,000	15,000	5,000	2,000	2,000	2,000	91,000
1.3.2	Support Integrated Training on HP Roles/Responsibilities for VDCs/HMCs/FMCs and Community Structures	-	-	10,000	10,000	5,000	5,000	3,000	3,000	36,000
	Subtotal	**-**	**45,000**	**30,000**	**25,000**	**10,000**	**7,000**	**5,000**	**5,000**	**127,000**
	Objective 1 Total	**400**	**45,400**	**36,230**	**56,400**	**12,100**	**38,600**	**7,100**	**6,600**	**202,830**
OBJECTIVE 2: STRENGTHEN NATIONAL HEALTH PROMOTION INTERVENTIONS										
SO 2.1	**Disseminate and Provide Guidelines on Use of Health Promotion Models**									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
2.1.1	Develop and Disseminate HP Model/Pathway Brochure and Orient Partners on HP Model/Pathway and Other Guidance through Standing Pillar Meetings	-	-	1,000	-	-	-	-	-	1,000
2.1.2	Hold Regular MOHS Stakeholders Meetings to Include a Mandate in the SLA for Partners to Base Programming on Approved HP Model/Pathway, and Other Guidance Documents (e.g., SM TOR)	-	-	50	50	50	50	50	50	300
	Subtotal	**-**	**-**	**1,050**	**50**	**50**	**50**	**50**	**50**	**1,300**
SO 2.2: Support National Integrated Efforts to Reach Adolescents with Health Promotion										
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					

2.2.1	Gather and Share Existing Evidence with National and District Partners on Adolescent Health Behaviors through HED Knowledge Gateway	-	-	-	-	-	-	-	-	-
2.2.2	Conduct Biannual Meetings between HED and the School Health Program/Secretariat of Teenage Pregnancy to Strengthen Collaboration	-	100	-	100	200	200	200	200	1,000
2.2.3	Support Adolescent Campaign Design and Implementation	-	-	10,000	45,000	55,000	40,000	30,000	25,000	205,000
2.2.4	Support Advocacy on the Need to Reach Adolescents (e.g., Religious and Community Leaders)	-	-	-	-	25,000	-	-	-	25,000
2.2.5	Facilitate Community-level Adolescent-focused Program Activities	-	-	-	-	16,000	30,000	25,000	25,000	96,000
	Subtotal	**-**	**100**	**10,000**	**45,100**	**96,200**	**70,200**	**55,200**	**50,200**	**327,000**
SO 2.3: Strengthen Community-level Actors in Health Promotion										
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
2.3.1	Conduct Mapping of Materials/Job Aids for Community-level Actors and Supporting Partners to Identify Gaps	-	-	14,000	-	-	1,000	-	1,000	16,000
2.3.2	Develop Health Promotion Materials/Job Aids for Community-level Actors Based on Mapping/Review	-	-	-	-	51,500	55,000	-	-	106,000
2.3.3	Provide Opportunities (Training) for Community-level Actors to Use Health Promotion Materials and Become Health Promotion Advocates	-	-	-	-	-	-	75,000	25,000	100,000
2.3.4	Conduct Mapping of Materials/Job Aids for In-service Healthcare Workers to Identify Gaps	-	-	7,500	-	-	3,000	-	3,000	13,500
2.3.5	Develop Health Promotion Materials/Job Aids for Interpersonal Communication Skills for In-service Healthcare Workers	-	-	-	-	51,000	55,000	-	-	106,000
2.3.6	Provide Training for In-service Healthcare Workers on	-	-	-	-	-	-	100,000	80,000	180,000

	Interpersonal Communication Skills and Using Job Aids/Materials and Provide Follow-up Support (Incentives, Mentoring, Supportive Supervision)									
	Subtotal	**-**	**-**	**21,500**	**-**	**102,500**	**114,000**	**175,000**	**109,000**	**522,000**
SO 2.4: Establish Evidence-base on Behaviours and Communication Channels to Guide Programming										
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
2.4.1	Conduct Desktop Analysis to Identify Evidence Gaps on Knowledge, Attitudes, Practices and Behaviors Related to Priority Health Areas and Audiences	-	-	-	3,100	-	-	-	-	3,100
2.4.2	Support the Design, Implementation and Dissemination of Studies to Fill Gaps in Evidence (See 2.4.1)	-	-	-	-	5,000	55,000	5,000	55,000	120,000
2.4.3	Orient Government Agencies and Partners on Using Evidence in SBCC Programming	-	-	-	-	6,500	-	-	6,500	13,000
2.4.4	Facilitate National Communication Channels Assessment to Map Existing Approaches and Effectiveness, Selecting Key Channels/Approaches (e.g., Radio, Mobile, TV, Community Engagement)	-	-	-	-	-	-	24,720	-	-
2.4.5	Based on Assessment, Invest in Select Communication Channels for Health Promotion (See 2.4.4)	-	-	-	-	-	10,200	113,200	-	123,400
	Subtotal	**-**	**-**	**-**	**3,100**	**11,500**	**65,200**	**142,920**	**61,500**	**284,220**
SO 2.5	**Develop and Launch a National Health Promotion Campaign**									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
2.5.1	Develop a National Health Promotion Campaign that	-	-	-	-	125,000	-	-	-	125,000

	Includes a National Logo									
2.5.2	Hold National- and District-level Campaign Launches	-	-	-	-	21,000	-	-	-	21,000
2.5.3	Roll Out National Campaign (e.g., Broadcast, Print Distribution)	-	-	-	-	60,000	-	-	-	60,000
2.5.4	Monitor and Evaluate National Campaign Outcomes	-	-	-	-	-	20,000	20,000	20,000	60,000
	Subtotal	**-**	**-**	**-**	**-**	**206,000**	**20,000**	**20,000**	**20,000**	**266,000**
SO 2.6	**Facilitate Development of an Emergency Communication Plan**									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
2.6.1	Contribute to Emergency Communication Plan and Training Curriculum	-	-	-	-	-	-	-	-	-
2.6.2	Support Emergency Communication Training at District-level	-	-	-	-	10,000	-	-	-	10,000
	Subtotal	**-**	**-**	**-**	**-**	**10,000**	**-**	**-**	**-**	**10,000**
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
SO 2.7	**Strengthen Integration of Health Promotion Activities with Activities in Other Sectors – e.g., Education, Agriculture, Youth – to Achieve Health and Development Gains**									
2.7.1	Convene Multi-stakeholder Meetings with Relevant Ministries to Integrate Health Promotion	-	-	-	2,000	-	2,000	-	2,000	6,000
2.7.2	Assign HP Role (e.g., Seconded, Focal Point) to Support HP Activities in Four Ministries (e.g., Education, Agriculture, Youth, Gender)	-	-	-	-	-	-	-	-	-

	Subtotal				**2,000**		**2,000**		**2,000**	**6,000**
SO 2.8	**Launch in Full Effect a National Public Health Information Line**									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
2.8.1	Conduct Resource Mobilization Activities and Secure Funding from Stakeholders	-	-	20,700	38,700	154,800	140,400	140,400	140,400	635,400
2.8.2	Set-up a Toll-free Hotline Number or Operationalize/Broaden the Scope of the Existing Ministry of Health's 117 Call Centre Line	-	-	-	-	57,900	27,900	57,900	27,900	171,600
2.8.3	Conduct Activities to Educate the Public on Using the Public Health Line	-	-	-	-	-	-	-	-	-
2.8.4	Integrate the Call Centre Approach to Health Promotion in all MOHS Strategic Plans as Part of Strengthening a Continuous National level Method of Health Promotion	-	-	1,500	-	-	-	-	-	1,500
2.8.5	Conduct Trainings for Call Centre Health Promotion and Information with Staff	-	1,500	1,500	1,500	6,000	6,000	6,000	6,000	28,500
	Subtotal	**-**	**1,500**	**22,200**	**41,700**	**218,700**	**174,300**	**204,300**	**174,300**	**837,000**
	Objective 2 Total	**-**	**1,600**	**54,750**	**91,950**	**644,950**	**445,750**	**597,470**	**417,050**	**2,253,520**
	OBJECTIVE 3: IMPROVE HUMAN RESOURCES AND CAPACITY STRENGTHENING FOR HEALTH PROMOTION									
SO 3.1	**Develop Training Program for Pre-service and In-service Health Promotion Professionals**									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					

3.1.1	Develop National Training Plan of In-service Training Opportunities for HP Professionals	-	-	15,000	-	-	-	-	-	15,000
3.1.2	Assign HED Staff to Attend International Health Conference (e.g., ASTMH, SBCC Conference) and Health Communication Study Tour (e.g., WHO)	-	-	-	-	4,500	-	-	4,440	8,940
3.1.3	Hold At Least One HP-focused Capacity Building TOT Per Year for HED and Partners at National/District Level (e.g., DSMCs) – As Per Training Plan	-	-	-	-	25,000	25,000	25,000	15,000	90,000
3.1.4	Hold a Strategic Health Communication Training in Sierra Leone (Repeated Every Three Years) – As Per Training Plan	-	-	-	-	-	45,000	-	-	45,000
3.1.5	For Pre-service Training, Assess and Finalize Potential Partnership with Training Institution(s)	-	-	-	-	2,500	2,500	-	-	5,000
3.1.6	Develop Curriculum with Selected Training Institution(s)	-	-	-	-	-	-	30,000	-	30,000
3.1.7	Provide Annual General Support to Institution to Implement Training, (e.g., Support for Faculty, Materials)	-	-	-	-	-	-	25,000	25,000	50,000
	Subtotal	**-**	**-**	**15,000**	**-**	**32,000**	**72,500**	**80,000**	**44,440**	**243,940**
SO 3.2	**Review and Update Human Resources for Health Policy to Include Health Promotion**									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
3.2.1	Update and Clarify HP Roles/Responsibilities, Terms of Service and Professional Development to Guide MOHS Leadership (Annually)	-	-	-	-	-	-	-	-	-
3.2.2	Advocate with MOHS Human Resources for Health and Partners to Influence Strengthening HED Workforce	-	-	-	-	-	-	-	-	-
	Subtotal	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

	Objective 3 Total	**-**	**-**	**15,000**	**-**	**32,000**	**72,500**	**80,000**	**44,440**	**243,940**
	OBJECTIVE 4: RAISE AWARENESS AND MOBILIZE RESOURCES FOR STRENGTHENED HEALTH PROMOTION									
SO 4.1	**Advocate for Increased Funding, Operational Support and Human Resources for Health Promotion Activities**									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
4.1.1	Develop Advocacy Plan to Identify Objectives, Key Audiences, Messages and Opportunities to Raise the Profile of HP and Mobilize Resources	-	-	-	-	-	11,000	-	-	11,000
4.1.2	Develop and Disseminate Evidence Briefs on Impact and Importance of HP in Sierra Leone	-	-	-	-	-	2,750	-	2,750	5,500
4.1.3	Hold Training for Journalists to Orient Press on Covering Health Promotion Stories	-	-	-	-	-	-	16,000	-	16,000
4.1.4	Hold National Media Event to Launch Evidence Briefs and Raise Visibility of Health Promotion	-	-	-	-	-	-	7,500	-	7,500
4.1.5	Orient District-level Decision-makers (e.g., District Council, VDCs, FMCs/HMCs) on Impact of HP via Advocacy “Road Shows”	-	-	-	-	-	-	-	20,000	20,000
4.1.6	Hold Advocacy Meeting with Parliamentary Health Committee to Showcase HP Successes and Advocate for Increased Funding for Health Promotion	-	-	-	-	-	-	-	-	-
	Subtotal	**-**	**-**	**-**	**-**	**-**	**13,750**	**23,500**	**22,750**	**60,000**
SO 4.2	**Engage at Least Five New Private Sector Institutions to Invest in National Health Promotion Activities**									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
4.2.1	Develop Private Sector Brochure Outlining Options for	-	-	-	-	-	5,000	-	-	5,000

	Investing in HP in Sierra Leone, with a Business Case for Investing in HP									
4.2.2	Hold Annual Business Networking Forums to Encourage Investments in Health Promotion	-	-	-	-	-	13,400	4,850	4,850	23,100
	Subtotal	**-**	**-**	**-**	**-**	**-**	**18,400**	**4,850**	**4,850**	**28,100**
	Objective 4 Total	**-**	**-**	**-**	**-**	**-**	**32,150**	**28,350**	**27,600**	**88,100**
	OBJECTIVE 5: IMPROVE MONITORING AND EVALUATION SYSTEMS FOR HEALTH PROMOTION									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
		Q1	**Q2**	**Q3**	**Q4**					
5.1.1	Hold Stakeholder Meeting to Agree on HP Monitoring Indicators and M&E Priorities for HP	-	-	-	500	-	-	-	-	500
5.1.2	Create M&E Subcommittee with a TOR within the SM Pillar, and Facilitate the Incorporation of M&E in the Implementation of All Health Promotion Activities	-	-	-	-	2,000	2,000	2,000	2,000	8,000
5.1.3	Identify an HP Staff Person to Focus on M&E and Represent HED in M&E Steering Committee Meetings	-	-	-	5,500	22,000	22,000	22,000	22,000	93,500
5.1.4	Develop M&E Framework with DPPI and Partner Support	-	-	-	-	-	-	-	-	-
5.1.5	Review and Incorporate Behavioral Indicators into Existing Monitoring Systems (e.g., HMIS)	-	-	-	-	-	-	-	-	-
5.1.6	Ensure HP M&E Framework is Included in MOHS M&E Trainings to Districts	-	-	-	-	-	-	-	-	-
	Subtotal	**-**	**-**	**-**	**6,000**	**-**	**24,000**	**24,000**	**24,000**	**78,000**
	Objective 5 Total	**-**	**-**	**-**	**6,000**	**-**	**24,000**	**24,000**	**24,000**	**78,000**

	OBJECTIVE 6: STRENGTHEN KNOWLEDGE SHARING AND MANAGEMENT									
		Year 1				Year 2	Year 3	Year 4	Year 5	Total
		Q1	Q2	Q3	Q4					
6.1.1	Develop a Knowledge Management Plan Based on 2016 Knowledge Management Assessment	-	-	-	-	-	-	-	-	-
6.1.2	Provide Technical Assistance to Districts to Implement Knowledge Management Plan	-	1,000	1,000	-	2,000	2,000	2,000	2,000	10,000
6.1.3	Ensure HED and District SM Coordinators Have Internet Connectivity and IT person at the National Level		10,000		10,000	40,000	40,000	40,000	40,000	180,000
6.1.4	Organize Electronic Files at HED (Maintaining the Knowledge Gateway)	-	-	-	-	-	-	-	-	-
6.1.5	Organize Hardcopy Files at HED (Completing Filing System)	-	-	-	-	-	-	-	-	-
6.1.6	Create Tailored Email Listservs that Include Relevant Partners	-	-	-	-	-	-	-	-	-
6.1.7	Create Electronic and Hardcopy Versions of Health Promotion Newsletter Quarterly for Nationwide Distribution	-	-	-	-	1,000	1,000	1,000	1,000	4,000
6.1.8	Ensure HED Page is on MOHS Website, Linking to Knowledge Gateway	-	-	-	-	-	-	-	-	-
6.1.9	Hold Best Practices Exchange Semi-annually through SM Pillar Meeting	-	-	-	-	3,500	3,500	3,500	3,500	14,000
	Subtotal	**-**	**11,000**	**1,000**	**10,000**	**46,500**	**46,500**	**46,500**	**46,500**	**208,000**
	Objective 6 Total	**-**	**11,000**	**1,000**	**10,000**	**46,500**	**46,500**	**46,500**	**46,500**	**208.000**
	Quarterly Total	6,,600	71,000	116,980	174,350	775,550	699,500	823,420	606,190	3,273,590

APPENDIX E. BUDGET NOTES FOR THE NATIONAL HEALTH PROMOTION STRATEGY (2017-2021)

This document provides the assumptions and estimating parameters used to develop the projected expenditures for a 5-year budget (January 2017- December 2021) in sufficient detail to permit analysis of proposed costs. We have presented supporting detail by cost element, and in cases where vendor estimates are not available, projections are based on our experience with projects of similar size and scope.

INCEPTION PHASE

0.1 **Q1, Y1: Launch the Health Promotion Strategy**: A national launch event with a press release and media will be held to raise awareness of the new strategy to MOHS officials and partners. Copies of the Strategy will be printed and disseminated to guests. Cost for the launch, which includes printing and refreshments, is estimated at **$2,000**.

0.2 **Q1, Y1: Orient District Teams on the Health Promotion Strategy**: Following the national launch, an orientation for representatives from all 14 districts will take place in Freetown. Costs will include travel expenses to Freetown for 26 district representatives, in addition to refreshments. Total cost is **$6,000**.

0.3 **Q1, Y1: Meet with at Least 10 Partners / Donors to Secure Commitments to Support Individual Activities**: In order to fund activities in this strategy, the HED will meet on several occasions with partners to determine which activity or set of activities they want to adopt or financially support. This activity will take place in the first quarter of 2017, and costs for this exercise include transportation, for a total amount of **$200**.

0.4 **Q1, Y1: Develop Detailed TOR for Proposed Technical Advisor**: The HED will develop a TOR defining the scope of work to recruit a technical advisor (see below). **There are no costs associated with this activity**.

0.5 **Q2, Y1: Recruit Technical Advisor to Support the HED:** Given the staff shortages within the HED, a technical advisor will be recruited to support the HED in implementing activities in this strategy. The HED will develop a TOR in the first quarter of 2017 but it is expected that this person will be primarily in charge of resource mobilization, M&E systems development, and capacity strengthening. This technical advisor could be seconded staff from partner organization. This person will be recruited in the second quarter of 2017, to be sustained through the five years. Estimated costs for this person is **$40,000 per year ($10,000 per quarter)**, for a total for the five years of **$190,000**.

OBJECTIVE 1: STRENGTHEN HEALTH PROMOTION STRUCTURES

SO 1.1: Rejuvenate the Social Mobilization and Communication pillars at National level and Strengthen Coordination Mechanisms

1.1.1 **Q1, Y1: Review, Update and Disseminate SM Pillar TOR**: HED developed a TOR for the SM Pillar, describing how it will function, the development of which partners supported. This TOR will be disseminated to government officials and key partners at the national level by email listservs and in-person during an SM Pillar meeting and the NGO forum, and will be maintained on the HED's Knowledge Gateway. The TOR will be reviewed yearly and updated as needed.

There are no costs associated with this activity.

1.1.2 **Q2, Q3, Yi: Support the Finalization and Dissemination of the Communications Pillar TOR**: HED is supporting the finalization of the TOR for the Communications Pillar. Similar to the SM Pillar TOR, this TOR will be disseminated to government officials and key partners at the national level by email listservs and in-person during a Communications Pillar meeting and the NGO forum, and will be maintained on the HED's Knowledge Gateway. The TOR will be reviewed yearly and updated as needed.

There are no costs associated with this activity.

1.1.3 **Y1-Y5: Hold Monthly (more as necessary) National SM Pillar Meetings**: SM Pillar chairs HED with UNICEF will host these meetings every month, with additional meetings called as needed. Meeting minutes will be taken and circulated to inform other partners and district level representatives of key outcomes. At least one HED representative from the SM Pillar will also attend the Communications Pillar, and report to the respective Pillars on activities to ensure coordination. Estimated costs are $600 per year refreshments, printing, etc. ($50/two meetings per month).

Estimated total cost for the five years is$3,000.

1.1.4 **Y1-Y5: Hold Regular National Communications Pillar Meetings (PHNEOC) Every Two Weeks:** The HED has seconded a staff member to help lead the Communications Pillar, which the CDC is also supporting. At lest one HED representative from the Communications Pillar will also attend the SM Pillar, and report to the respective Pillars on activities to ensure coordination. Estimated costs are $600 per year refreshments, printing, etc. ($50/two meetings per month).

Estimated total costs for the five years is $3,000.

1.1.5 **Y1-Y5: Participate in Inter-Pillar Meetings at National Level Called by PHNEOC for Improved Coordination**: One HED representative will participate in Inter-Pillar meetings, which are scheduled on an as needed basis to ensure coordination with other national efforts, including the SM and Communications Pillars.

There are no costs associated with this activity.

1.1.6 **Y2 & Y4: Conduct Periodic Capacity Assessment for Strengthening National SM Pillar and Provide Support**: A health promotion capacity assessment of SM Pillar members will occur once every two years (Y2 and Y4). Based on those results, additional support will be provided through SM Pillar meetings and other partners based on their technical expertise. This activity will involves:

- Y2 & Y4: Using capacity assessment tools and facilitating two, 2-day meetings with key partners in the SM Pillar. A technical support person will guide participants through filling out the survey tools during the meetings. Estimated costs are $350 for lunch and refreshments (30 people at $11.67 per person), plus $150 for local transportation ($5 per person for 30 people) for an estimated total of $1,000 ($500 per year).
- Y2 & Y4: Technical support will be provided based on results. The Pillar can address and recruit partners to help provide that support during special sessions in SM Pillar meetings and other channels.

Estimated total cost for this activity is $1,000.

SO 1.2: Rejuvenate the Social Mobilization pillar at District Level and Strengthen Coordination Mechanisms

1.2.1 **Q1, Y1: Review, Update and Disseminate District Level SM Pillar TOR**: Similar to the national level SM Pillar TOR, the HED is developing a TOR for the district-level SM Pillars. This TOR will be disseminated to government officials and key partners at the district and national level by email listservs and in-person during national and district-level SM Pillar meetings, and will be maintained on the HED's Knowledge Gateway. The TOR will be reviewed yearly and updated as needed.

There are no costs associated with this activity.

1.2.2 **Q2-Q3, Y1: Map Active SM Pillar Partners and Identify Dormant SM Pillars**: A stakeholder mapping meeting will be held to identify which district SM Pillars are dormant, and determine who will be responsible for certain roles within the pillar (e.g., inviting partners, chairing meetings, meeting minutes, etc.), and to determine additional support needs to rejuvenate and sustain them. Assuming the venue will be the district offices, estimated costs to conduct the mapping include sending two people from Freetown to 13 Districts, totaling $2,180 ($15 for 2 people for transportation totaling $390, $15 for 2 people for meals totaling $390, $54 for lodging for 2 people totaling $1,400) and lunch during the stakeholder meeting for $3,150 (approx. $15 per person for 210 people [15 per district) x 14 districts).

Estimated total cost for this activity is $5,330.

1.2.3 **Q4, Y1: Hold a Revitalization Meeting to Present Mapping Landscape with Recommendations, TOR and Roles/Responsibilities**: Revitalization meetings will be held in each of the 14 districts following the mapping exercises, where district HP coordinators and district pillar leads will present the findings from the mapping exercises, along with the district-level TORs, and clarified roles and responsibilities. Estimated costs for these meetings are for refreshments for 14 districts (approx. 15-20 people per district for $74 per district).

Estimated total cost for this activity is $1,000.

1.2.4 **Q4, Y1: Conduct Two-Day Capacity Assessment Meeting and Provide Support (e.g., Training) for all District SM Pillars**: Using a similar process to the national level health promotion capacity assessment (above), district-level assessments will be held with district representatives and partners. Similar to the process described for the national level assessment, a 2-day facilitated capacity assessment meeting will guide participants in filling out the survey tools. Based on results, an action plan will be developed to fill in gaps with technical assistance (TA). TA will not necessarily be the same each time. The cost for the assessment is estimated at $2,800 for the 2-day meetings in all districts ($200 per meeting x 14 districts), and $5,600 for travel experiences for two HED staff from Freetown to each of 14 districts ($200 x 2 people x 14 districts). At a minimum, estimated costs for providing additional TA will be approximately $12,000 ($3,000 per year starting in Y2) to cover local travel, partner assistance, tools, training, supervision, or many things together.

Estimated total costs for this activity is $20,000.

1.2.5 **Y1-Y5: Hold Monthly District-level SM Pillar Meetings (more frequently as needed), and Circulate Meeting Minutes**: As part of the rejuvenation process, the district-level SM Pillar meetings will be supported with refreshments. Meeting minutes will be taken and circulated to inform other partners and

national level representatives of key outcomes. Costs for refreshments will be approx. $400 per year ($16.70 x 12 monthly meetings for 14 districts).

Estimated total costs for this activity for the five years are $2,000.

1.2.6 **Y1-Y5: Participate in Monthly District Coordination Meetings**: One district-level Health Promotion (HP) Coordinator will participate in monthly district coordination meetings, scheduled on an as needed basis, to ensure coordination with other efforts, such as surveillance, and will report back to the national office.

There are no costs associated with this activity.

1.2.7 **Q2-Q3, Y1: Map and Develop MOUs with Functional Community Radio Stations in Each District for Message Dissemination**: The HED will support this activity, which UNICEF is conducting. It is likely that the MOUs will be between UNICEF and the stations, but will be shared with MOHS. Estimated costs for this activity include two trips from Freetown to the 14 districts, at approximately $500 per first round of visits.

Estimated total costs for the 2 visits are approximately$1,000.

SO 1.3: Strengthen Community-level Actors and Foster Community Ownership of Health

1.3.1 **Y1 (Q2-Q4)-Y5: Develop and Disseminate Guidance on HP Roles and Responsibilities for Community Structures (e.g., VDCs, HMCs/FMCs, CHWs, Community Groups, etc.):** Integrated health promotion guidelines will be rolled out to these community-level structures and groups. This will involve the following:

- Y1: Community stakeholder meetings at district level to develop a system for feedback between the community and appropriate district and national structures (this could be based on the mapping exercise noted above). This would include roles/responsibilities with accountability mechanisms for addressing community concerns. Estimated costs for the first year total $80,000 ($45,000 for consultant fees and community meetings, $20,000 to support focus group discussions at the district and community level in select regional centers to develop guidance, additional stakeholder meetings to review FDG findings with community-level validation, and $15,000 for printing and dissemination).
- Y2-5: Remaining years--$5,000 for year 2, and $2,000 every year afterward—Include follow-up and re-printing, where needed.

Total estimated total costs for this activity is$91,000.

1.3.2 **<u>Y1 (Q3-Q4)-Y5: Support Integrated Training on HP Roles/Responsibilities for VDCs/HMCs/FMCs and Community Structures</u>**: This activity supports training that UNICEF or others are conducting with community groups, to ensure HP in on the agenda. Trainings will be conducted to clarify the VDCs' and associated community groups' health promotion roles and to strengthen them in this role. This includes orienting national, district and community stakeholders on the guidance developed above (233 meetings including 218 wards/ meetings, 14 district meetings and 1 national meeting). Estimated costs for cascade training from national to district level include approx. $4,600 per district with an additional $5,000 for national coordination. These estimates are based on 1 PHU staff and 1 VDC member attending trainings held at district level (e.g., 5 trainings per district). Trainings could be simultaneous, meaning there would need to be multiple trainers of district and national teams. Additional coordination costs cover fees, fuel, travel, coordination, communication, etc. Estimated costs for refreshments and printing are included in year 5.

Total estimated costs for support for this activity is$36,000.

OBJECTIVE 2: STRENGTHEN NATIONAL HEALTH PROMOTION INTERVENTIONS

SO 2.1: Disseminate and Provide Guidelines on Use of Health Promotion Models

2.1.1 **Q3, Y1: Develop and Disseminate HP Model/Pathway Brochure and Orient Partners on HP Model/Pathway and other Guidance through Standing Pillar Meetings**: Shortly after the launch of the HP Strategy, an HP model brochure will be developed and disseminated to partners, who will be oriented on the models and other guidance documents (e.g., SM TOR, etc.) through standing Pillar meetings, Knowledge Gateway, listservs, etc. Estimated costs for this activity are for color printing of a 1-page brochure totaling approximately $100.

Estimated total costs for this activity are $100.

2.1.2 **Y1 (Q3-Q4)-Y5: Hold Regular MOHS Stakeholders Meetings to Include a Mandate in the SLA for Partner to Base Programming on Approved HP Model/Pathway and Other Guidance Documents (e.g., SM TORs):** These meetings will begin in Y1, starting in Q3 and repeated in Q4. For the remaining years, there will be one annual meeting for follow-up as needed. Estimated costs cover refreshments $300 ($50 x 2 in Y1 plus $50 x 3 for Y3-5).

Estimated total costs for this activity are $300.

SO 2.2: Support National Integrated Efforts to Reach Adolescents with Health Promotion

2.2.1 **Y1 (Q3-Q4)-Y5: Gather and Share Existing Evidence with National and District Partners on Adolescent Health Behaviors through HED Knowledge Gateway**: This activity involves gathering existing adolescent health-related evidence, adding it to the HED Knowledge Gateway, promoting and disseminating the link to these resources to national/district partners, and ensuring Knowledge Gateway point person within the HED leads efforts to ensure new evidence is uploaded as it is developed.

There are no costs associated with this activity.

2.2.2 **Y1 (Q2 & Q4)-Y5: Conduct Bi-annual Meetings between HED and the School Health Program / Secretariat of Teenage Pregnancy to Strengthen Collaboration**: These bi-annual meetings ensure health promotion is strengthened and coordinated for adolescents in schools and communities. Each meeting will have an agenda and objectives, along with meeting minutes. Estimated costs for these meetings are $1,000 ($100/per meeting x 2 per year x 5 years).

Estimated total cost for the five years is$1,000.

2.2.3 **Y1 (Q2 & Q4)-Y5: Support Adolescent Campaign Design and Implementation**: Technical and financial support will be provided to the Secretariat of Teenage

Pregnancy and other partners as needed to carry out an adolescent-focused campaign. This activity will complement activities the Secretariat of Teenage Pregnancy is already leading, broadening them where necessary. Estimated costs for this activity will include technical and financial support to scale up a national adolescent campaign, which may include filling research gaps, strategy and messaging development, campaign materials, national/district advocacy events, and multi-media programming including mobile platforms focused on adolescents. At a minimum, it is estimated that this support would be approximately $50,000 ($10,000 per year starting in Y1).

Total estimated costs for this activity, which will also serve as an investment in mass media for health promotion, is$50,000.

2.2.5 **Y2: Support Advocacy on the Need to Reach Adolescents (e.g., Religious & Community Leaders**): HED will also provide support to the Secretariat of Teenage Pregnancy and others working on adolescent health by conducting advocacy on the need to reach adolescents. Estimated costs include a one-day orientation meeting for the media to cover adolescent health issues and the adolescent-focused campaign (see 2.2.3), totaling $7,000 (e.g., costs for transportation, lunch, venue and printing for approx. 50 journalists) and a one-day orientation to community and religious leaders through formal structures (e.g., Inter-Religious Council) at the national level, to be rolled out to the district level through cascade trainings, totaling $18,000 (e.g., costs for transportation, lodging, meals, printing for 14 districts at $1,285 per district).

Estimated total costs for this activity is$25,000.

2.2.6 **Y2-Y5: Facilitate Community-level Adolescent-focused Program Activities**: Adolescent-focused community engagement activities will also be supported through the Secretariat of Teenage Pregnancy. Estimated costs include the following:

- Y2: Consultant to adapt an existing community engagement (CE) platform (e.g., *CLEA, Journey of Hope)* to focus on adolescent health issues, totaling an estimated $10,000 ($500/day for 10 days totaling $5,000, and 5 days travel at approximately $5,000).
- Y2: Pretest CE platform for an estimated cost of $6,000.
- Y3: Printing of CE materials for an estimated cost of $10,000.
- Y3: Cascade trainings in select districts for an estimated cost of $20,000.
- Y4 and Y5: Implementation in select communities, with costs to include oversight/supervision and monitoring (approx. $25,000 each in Y4 & Y5).

Estimated total costs for this activity is$96,000.

SO 2.3: Strengthen Community-level Actors in Health Promotion

2.3.1 **Y1 (Q3), Y3, Y5: Conduct Mapping of Materials/Job Aids for Community-level Actors and Supporting Partners to Identify Gaps**: A request will be made at the national and district levels and through existing forums such as the NGO forum to collect all health promotion materials for community-level actors[8], followed by a series of review meetings to review and catalogue all materials/job aids (e.g., good, bad, friendly, outdated, etc.), where the good ones are uploaded to the HED Knowledge Gateway. Additional reviews will occur in Y3 and Y5, with sessions taking place through existing channels and meetings (e.g., SM Pillar meetings). Estimated costs for this activity include approximately $6,500 for the initial mapping exercise in Q3,Y1, which includes travel costs to bring materials from the 14 districts, and refreshments for review meetings, followed by $1,000 every two years to review and catalogue additional materials. Partners will be reached to update outdated materials.

Estimated total cost for this activity is$7,500.

2.3.2 **Y2-Y3: Develop Health Promotion Materials/Job Aids for Community-level Actors Based on Mapping/Review:** Where there are gaps identified in the review above, additional materials/job aids will be developed. Estimated costs for this activity, spread out across Y2 and Y3, involves hiring a consultant to lead development efforts (20 days @ $500/day and travel and other expenses, $20,000), starting with identifying materials/job aids that need updating or developing, holding a 2-day workshop with key district and national level stakeholders to agree on messages and images for the new materials/job aids ($6,500), developing a scope of work and hiring an advertising firm/graphic designers to produce the materials ($25,000), pretesting the materials in at least two districts ($5,000), and printing and distributing the materials to all of the 14 districts for wider community-level distribution among partners ($50,000).

Estimated total cost for this activity is $106,500.

2.3.3 **Y4-Y5: Provide Opportunities (Training) for Community-level Actors to Use Health Promotion Materials and Become Health Promotion Advocates**: Cascade training rolled out across the districts in Y4 and Y5 will orient community agents to harmonize messages, use the job aids/materials, gain effective communication skills, and understand the appropriate role they play in a national system of health promotion. This activity includes developing a cascade training curriculum, identifying facilitators, selecting participants (see example change agents above in 2.3.1), conducting community entry activities, and supervising the roll out of the orientations. Estimated costs for these

[8] Community level actors, or change agents, include but are not limited to CHWs, TBAs, VDCs, and community groups such as traditional healers, market women's associations, community leaders such as traditional leaders, women's and youth group leaders, social heads, drivers' unions, bike riders, and teachers.

activities include a 3-day TOT workshop ($30,000), printing ($8,000), and implementation of the orientations communities throughout the 14 districts ($25,000).

Estimated total cost for this activity is $63,000.

2.3.4 **Y1 (Q3), Y3, Y5: Conduct Mapping of Materials/Job Aids for In-service Healthcare Workers to Identify Gaps**: Similar to the mapping exercise above, a request will be made to collect materials and job aids (e.g., counseling aids, interpersonal communication materials) for in-service healthcare workers, followed by a series of review meetings to review and catalogue all materials/job aids (e.g., good, bad, friendly, outdated, etc.), where the good are uploaded to the Knowledge Gateway. Reviews will occur annually, with sessions taking place through existing channels and meetings. Estimated costs for this activity include approximately $7,500 for the initial mapping exercise in Q3, Y1, which includes travel costs to bring any hardcopy materials from the 14 districts, support to partners and venue/refreshments for the review meetings, followed by $6,000 ($3,000 every two years) to review additional materials in Y2 & Y5. Partners will be reached to update outdated materials.

Estimated total cost for this activity is $13,500.

2.3.5 **Y2-Y3: Develop Health Promotion Materials/Job Aids for Interpersonal Communication Skills for In-service Healthcare Workers:** Where there are gaps identified in the review above, additional materials/job aids will be developed. Estimated costs for this activity, spread out across Y2 and Y3, involves hiring a consultant to lead development efforts (e.g., 20 days @ $500/day and travel and other expenses, $20,000), starting with identifying materials/job aids that need updating or developing, holding a 2-day workshop with key district and national level stakeholders to agree on messages and images for the new materials/job aids ($6,500), hiring graphic designers to produce the materials ($25,000), pretesting the materials ($5,000), and printing and distributing the materials to all of the 14 districts for wider community-level distribution among partners ($50,000).

Estimated total cost for this activity is $106,500.

2.3.6 **Y4-Y5: Provide Training for In-service Healthcare Workers on Interpersonal Communication Skills and Using Job Aids/Materials and Provide Follow-up Support (Incentives, Mentoring, Supportive Supervision):** Cascade training in Y4 and Y5 rolled out to multiple staff from each facility will harmonize messages, use the job aids/materials and to gain effective interpersonal communication skills. This activity includes developing a cascade training curriculum, identifying facilitators, selecting participants (see example change agents above in 2.3.1), and supervising the roll out of the trainings. Estimated costs for these activities include a 3-day TOT workshop ($30,000), travel to the districts with lodging and

meals ($10,000), printing ($5,000), and refreshments and incentives for trainings throughout the 14 districts ($25,000).

Estimated total cost for this activity is $180,000.

SO 2.4: Establish Evidence-base on Behaviours and Communication Channels to Guide Programming

2.4.1 **Q4, Y1: Conduct Desktop Analysis to Identify Evidence Gaps on Knowledge, Attitudes, Practices and Behaviors Related to Priority Health Areas and Audiences:** Estimated costs for this activity include these activities:

- Develop a schedule of visits to MOHS programmes, key partners, anthropologists, donors and others, and gather information from them on what evidence exists. There are no costs associated with this activity.
- Hold a desktop review workshop as part of the M&E technical working group's health promotion sub-ground formed under Objective 5 ($3,000 for the 2-day desktop review workshop [ideally this will be one of the first tasks of the newly formed M&E subcommittee within the SM Pillar—see Objective 5).
- Present results to partners. There are no costs associated with this activity.

Estimated total cost for this activity is $3,000.

2.4.2 **Y2-Y5: Support the Design, Implementation and Dissemination of Studies to Fill Gaps in Evidence (see 2.4.1):** Following the desktop review, the following will occur:

- Y2: Conduct meetings with MOHS programmes, partners and donors to encourage them to design and conduct studies to fill gaps in KAP and behavioral evidence related to priority audiences and health areas. There are no costs associated with this activity.
- Y2: Develop a research plan based on the outcomes of those discussions, and updated each year as needed. This can be done through support from the M&E technical working group or the HED staff. There are no costs associated with this activity.
- Y3 & Y5: Conduct research based on the research plan, including designing the study and tools, selecting locations, training data collectors, and conducting the study. *It is anticipated that based on the research plan, partners will conduct these studies and assume these costs* ($50,000 for Y3 & Y5).
- Y2-5: Provide technical support to these partners through the M&E technical working group and district coordinators to ensure studies are coordinated, complementary and not duplicative, and reflect national health promotion priorities according to this Strategy. There are no costs

associated with this activity.

- Y2-5: Add all evidence and reports to the HED Knowledge Gateway and disseminated via NGO forums, listservs, SM and Communication Pillar meetings, HED newsletter (see Objective 6) and other channels. There are no costs associated with this activity.
- Y2-5: Starting in Q4 of Y2, convene partners to share evidence once a year in health communication evidence-sharing forums, which can be hosted by the M&E subcommittee of the SM Pillar (see Objective 5).

Estimated total cost for this activity is $100,000.

2.4.3 **Y2 & Y5: Orient Government Agencies and Partners on Using Evidence in SBCC Programming**: Through orientation meetings at the national level, national and district government representatives and partners will be briefed on how to use evidence in programming. These orientations will occur through existing channels and meetings once every two years. Estimated costs for this activity include travel for district representatives to Freetown, printing and refreshments, for $3,500 per meeting.

Estimated total cost for this activity is $7,000.

2.4.4 **Y4: Facilitate National Communication Channels Assessment to Map Existing Approaches and Effectiveness, Selecting Key Channels/Approaches (e.g., Radio, Mobile, TV, Community Engagement)**: With the support of technical partners (e.g., BBC Media, CDC), the HED will facilitate an assessment of communication channels used by the government and partners—such as radio, TV, mobile platforms and community engagement—to rate their effectiveness and select key channels that can serve multiple health needs and multiple partners. Estimated costs for this activity include the following:

- Y4: Develop a TOR and recruit a technical support person from a partner organization (or hire a consultant) to conduct consultations and a 2-day stakeholders meeting with key partners engaged in health promotion to map their communication channels—such as radio, TV, mobile platforms and community engagement—and rate their effectiveness. Estimated costs for this activity include a consultant for 10 days at $500/day for $5,000 plus travel expenses (if regional/international) for 5 days at $3,720, and a 2-day stakeholder meeting for $7,000, which includes travel expenses, venue and meals, totaling $12,000.
- Y4: Based on results from the meeting and existing evidence (e.g., 2016 BBC media report), develop an assessment report with recommendations describing the selection of key channels that can serve multiple health needs and partners—this will be used to guide investments in those channels. Validate the assessment with stakeholders in a one-day validation meeting, after which modifications will be made to the

assessment/recommendations. Estimated costs for this activity include a consultant for 5 days at $500/day for $2,500 and a one-day validation meeting for $3,500, totaling $6,000.

Estimated total cost for this activity is $21,720.

2.4.5 **Y3-Y4: Based on Assessment, Invest in Select Communication Channels for Health Promotion (see 2.4.4):** Estimated costs for this activity include these activities.

- Y3: Hire consultant to facilitate stakeholder consultations among partners implementing mobile platform programming (e.g., UReport, RapidPro, WhatsApp, GeoPoll) and develop recommendations for partnership, integration, development of mobile platform guidelines for adolescent health. Estimated cost for this activity is $10,000 ($500/day for 10 days totaling $5,000 plus 5 days travel at approximately $5,000).
- Y4: Present mobile platform guidelines and results of consultations to partners through existing channels and meetings—e.g., SM Pillar, Communications Pillar, listserves, the Knowledge Gateway—and advocate to partners to use mobile platforms in their health promotion programming. There are no costs associated with this activity.
- Y3-Y4: With technical support from a partner, HED will convene MOHS health programmes once a year to facilitate the coordination of key mass media and community engagement programmes to expanded impact so more programmes can benefit. Estimated cost of this activity is $400 ($200 per year for meeting refreshments).
- Y4: With technical support from a partner, hold a 2-day workshop to develop a plan and budget for the production of a national radio/TV show, using local content from local partners. Estimated cost is $16,000 ($11,000 for media consultant to facilitate - $600/day for 10 days including 5 days travel for approximately $5,000 - and a 2-day workshop, including travel, lodging for district representatives).
- Y4: Conduct meetings with donor organizations and partners to request financial and coordination support for the production of the national radio/TV show, using local content from local partners. Estimated cost for the production and broadcast of a radio/TV show is approximately $92,000 ($3,000 per episode x 24, and $20,000 for broadcast for a total of $92,000).

Estimated total cost for this activity is $118,400.

SO 2.5: Develop and Launch a National Health Promotion Campaign

2.5.1 **Y2: Develop a National Health Promotion Campaign that Includes a National Logo**: A well-planned coalition-based national platform from which to address public health will be developed. One feature of such a campaign will be a national logo and/or slogan to symbolize health that can be adopted by the MOHS and all of its partners. This activity will include the following costs:

- Y2: Conduct a stakeholder meeting to develop creative brief for campaign, during which existing evidence will be reviewed for an estimated **$15,000** (3-day meeting, which includes bringing in district representatives and beneficiaries).
- Y2: Hire an ad agency and design and develop campaign based on creative brief for an estimated **$50,000** (ad agency to develop campaign design, jingle, radio spot, poster, and logo)
- Y2: Pretest campaign concept and campaign products for an estimated **$10,000**
- Y2: Produce key campaign products – e.g., print, media, etc. for an estimated **$50,000.**
- Y2: Disseminate campaign products via HED Knowledge Gateway, list serves, and existing channels and meetings at the national and district level.

There are no costs associated with this activity.

Estimated total cost for this activity is $125,000.

2.5.2 **Y2: Hold National- and District-level Campaign Launches:** Awareness of the national campaigned will be raise through national and district level launches, which will include:

- Y2: Media briefing at the national level for an estimated $1,000
- Y2: National launch in a hall with refreshments and media for an estimated $7,000.
- Y2: Local launches in each of the 14 districts for an estimated $13,000 (approx. $930 per district)

Estimated total cost for this activity is $21,000.

2.5.3 **Y2: Roll Out National Campaign (e.g., Broadcast, Print Distribution)**: Campaign print materials will be distributed to the districts for the PHUs, community centers and other appropriate areas and jingles and radio spots will be broadcast nationwide.

- Y2: Set agreements with radio stations to broadcast radio jingles and radio spots on a schedule ($50,000 for community and national broadcasts)

- Y2: Distribute print materials to the districts ($10,000 for print distribution)

Estimated total cost for this activity is $60,000.

2.5.4 **Y2-Y5: Monitor and Evaluate National Campaign Outcomes:** The national campaign implementation will be monitored through surveys at the district level. This involves developing indicators, survey questions and a monitoring form and conducting periodic surveys on a random sample of beneficiaries (e.g., campaign message awareness, motivated to change behavior, etc.). Routine health promotion monitoring surveys or other mechanisms can also be tapped into via the M&E technical working group ($20,000 each year for three years [$1,400 per district] from Y3 to Y5 - incudes contracting local partner/data collectors to collect the data).

Estimated total cost for this activity is $60,000.

SO 2.6: Facilitate Development of an Emergency Communication Plan

2.6.1 **Y1: Contribute to Emergency Communication Plan and Training Curriculum**: An Emergency Communication Plan started by the Communication Pillar in 2016 will be finalized. This will involve HED participation in stakeholders meeting to identify roles and responsibilities for Emergency Communication implementation, attending the launch and dissemination of the Emergency Communication Plan, and contributing to the development of a training curriculum in emergency communication for district level.

There are no costs associated with this activity.

2.6.2 **Y2: Support Emergency Communication Training at District-level**: The Emergency Communication training will be rolled out to the district level, requiring support. Support will be provided in terms of printing and recruiting district-level trainers.

Estimated total cost for this activity is $10,000.

SO 2.7: Strengthen Integration of Health Promotion Activities with Activities in Other Sectors – e.g., Education, Agriculture, Youth – to Achieve Health and Development Gains

2.7.1 **Y1, Y3, Y5: Convene Multi-stakeholder Meetings with Relevant Ministries to Integrate Health Promotion:** Meetings with various Ministries within the Government of Sierra Leone—such as those focusing on education, agriculture, youth, gender, and others—every two years to integrate health promotion with other development areas where it makes sense, and review progress over time. These will also result in consensus on roles and responsibilities, and ensuring there are adequate and capable health promotion point people in each of the collaborating Ministries. Each meeting will have an agenda and objectives;

meeting minutes will be taken and shared. Estimated costs for this activity are $6,000 (3 meetings at $2,000 per meeting, which includes printing, materials, travel expenses for select representatives from the districts and lunch).

Estimated total cost for this activity is $6,000.

2.7.2 **Y3-Y5: Assign HP Role (e.g., Seconded, Focal Point) to Support HP Activities in Four Ministries (e.g., Education, Agriculture, Youth, Gender**): The MOHS will assign a health promotion role to support these Ministries with health promotion training and resources, and this person will providing technical support for health promotion activities, including providing training to staff, identify and address issues, and identify opportunities for harmonized communication, where needed.

2.8 Full Launch of a National Public Health Information Line

2.8.1 **Y1-Y5, Set up a Toll-free Hotline Number or Repurpose an Existing Line, such as the Ministry of Health's 117:** Depending on whether a new toll-free number is launched, the cost for call centre set -up will include leasing E1 lines, an information and communications technology (ICT) infrastructure and power set-up, operators, workstations, and software. The below costings are based on the model of using an already existing system. For this, there will no initial set-up costs, but rather monthly operational costs.

- **Y1 (Q3-4)–Y2**: Software maintenance and upgrades is $1,200/mo x 18 months totaling $21,600
- **Y1 (Q3-4)–Y5**: ICT and network equipment maintenance = $1,500/mo x 54 months totaling $81,000
- **Y1 (Q3-4)–Y5**: Management fees, including monitoring and robust analysis= $3,500/mo x 54 totaling $189,000
- **Y1 (Q3-4)–Y5**: Call centre manager system(Cisco or DigiumExlastix) = $500/mo x 54 months totaling $27,000
- **Y1 (Q3-4)–Y5**: Stationery = $200/mo x 54 months totaling $10,800
- **Y1 (Q4)–Y5**: 15 operators at $6,000/mo (15 x $400 per operator) x 51 months totaling $306,000

Estimated total monthly cost for the entire activity from Y1, Q3-4 to Y5 is $635,400.

2.8.2 **Y2 - Y5 Conduct Activities to Educate the Public on the Use of the Public Health Line:**Public awareness is an integral component of setting up a public health line. Regular media engagement, community engagement and other form of social mobilization are to be used.

- **Y2-Y5**: Media Engagement (radio discussions, etc. :$2,400/year ($200/mo x 12) for four years, totaling $9,600.
- **Y2 & Y4**: Community Engagement conducted once every two years for a cost of $30,000 per year (Transportation, DSA, Miscellaneous) totaling $60,000
- **Y2-Y5**: Annual training for social mobilizers at $7,500 per annual training for four years totaling $30,000

- **Y2-Y5**: Posters, flyers, bill boards/ banners and other display material and printing for a cost of $18,000 per year for four years totaling $72,000

Estimated total cost for this activity from Y2 to Y5 is $171,600.

2.8.3 **Y2 - Y5 Integrate a Call Centre Approach in all National level Strategic Plans as Part of Strengthening Health Promotion:** HED will need to prioritize the functioning of the national public health line, by ensuring that its activities are a part of all strategic efforts toward health promotion and behavior change modification.

Government released planning documents will include this initiative.

There are no costs associated with this activity.

2.8.4 **Y1 (Q4) - Y5 Conduct Trainings for Staff on Promoting Optimal Health Behaviors via the Call Centre:** An initial full training will be done for call centre staff with regular *ad hoc* refresher trainings that have no added costs. HED will provide the knowledge base materials for health promotion overarching topics and eHealth (or other partner) will support in facilitating the trainings.

Estimated total cost for the initial training is $1,500.

2.8.5 **Y1-Y5 Advocate for Funding and other Revenue Generating Activities with Stakeholders:** The public health line can be funded by a number of partners who focus on different types of public health issues. MoHS along with HED will engage with the health NGO community to incite interest in the use of such a system. Partners can then in turn contribute towards call centre activities and keep it operational.

Regular stakeholder meetings and workshops will be an instrumental component of this activity. HED to potentially hire a public health line focal person at $6,000 a year ($500 x 12), starting in Y1 and continuing into Y5.

Estimated costs for this activity from Y1 to Y5 is $30,000.

OBJECTIVE 3: IMPROVE HUMAN RESOURCES AND CAPACITY STRENGTHENING FOR HEALTH PROMOTION

SO 3.1: Develop Training Program for Pre-service and In-service Health Promotion Professionals

3.1.1 **Q2, Y1: Develop National Training Plan of In-service Training Opportunities for HP Professionals:** A budgeted plan for in-service training will ensure that curricula, methods, participants and activities are planned and comprehensive. The nationwide plan, which will be updated every two years, will include the following:

- Basic programme on health promotion principles and practices,
- Brief refreshers on technical areas such as health topics, risk communication, use of media and use of data
- Use of a blended learning approach to include
    - face-to-face and virtual learning opportunities,
    - resources such as job aids and best practices,
    - learning opportunities such as "internships," mentoring opportunities for staff, and
    - participation in technical working groups and conferences.

The plan will need to be costed and invested in by donor organizations and partners. Developing this plan will require technical support to lead a 2-day workshop with national and district level stakeholders who will identify priority health topics and training gaps, with travel expenses for district level representatives, and technical assistance to develop the plan.

Estimated total cost for this activity is $15,000.

3.1.2 **Y2-Y5: Assign HED Staff to Attend International Health Conference (e.g., ASTMH, SBCC Conference) and Health Communication Study Tour (e.g., WHO):** Financial support will be provided for HED staff to attend an international health conference featuring SBCC topics per year, and to attend a study tour to learn best practices from other countries. The staff member will present learnings to the national and district level staff. This activity includes:

- One study tour organized by a partner (e.g., WHO) to learn best practices in health communication for 2 people within the HED for an estimated $4,440 ($3,000 for regional airfare [2 x $1,500], and approx. $1,440 for per diem [approx. $240 x 2 people x 3 days]).
- One international health conference for 1 HED staff person per year totaling $4,500 ($2,500 for airfare, $2,000 for per diem [approx. $400 for lodging/per diem for 5 days]).

Estimated total cost for this activity is $8,940.

3.1.3 **Y2-Y5: As Per Training Plan, Hold At Least One HP-focused Capacity Building TOT Per Year for HED and Partners at National/District Level (e.g., DSMCs):** A technical support person from a partner organization will help develop, lead and support the trainings, which will include health topics such as compassionate communication, risk communication, etc. Prior to the workshop, training modules will be developed (including an advocacy module with budgeting exercises). Estimated costs for a five-day training is $25,000 per workshop for Y2-Y4, which includes travel expenses for district level staff, and $15,000 for Y5, for a shorter, refresher course.

Estimated total cost for this activity is $90,000.

3.1.4 **Y3: Hold a Strategic Health Communication Training in Sierra Leone (Repeated Every Three Years):** Following the success of the Johns Hopkins Center for Communication Programs (CCP) *Leadership Training in Strategic Communication* training in 2016, these certificate training programmes will continue to be held every three years for HED staff at the national and district level and partners. Estimated costs include all expenses for the 2-week training course for approximately 30 people, including venue, travel, lodging, and meals, and international travel expenses and consulting expenses for regional facilitators (e.g., CCPN, Nigeria).

Estimated total cost for this activity is $45,000.

3.1.5 **Y2-Y3: For Pre-service Training, Assess and Finalize Potential Partnership with Training Institution(s):** Pre-service training partnerships will be developed with one or more postgraduate training colleges. This activity is a particular priority for this strategy. The HED will set up meetings with the University of Makeni (UNIMAK), a private Catholic university, the College of Medicine and Allied Health Sciences (COMAHS) and the Postgraduate Training institution that the MOHS is planning to explore partnerships and pre-service training options. This activity will start in Y2 and continue through Y3 and will require the HED and a technical support person from a partner organization (or consultant) to gather information and develop an assessment of the potential partnerships. Estimated costs will include transportation and consultation fees for developing an assessment report with recommendations, estimated at $2,500 per year.

Estimated total cost for this activity is $5,000.

3.1.6 **Y4: Develop Curriculum with Selected Training Institution(s):** A resulting pre-service training programme—with one or more local training institutions, tailored for developing specific competencies—will be required for public and voluntary sector employers. WHO will be contacted to provide support/technical assistance to hire a consultant to develop the curriculum. Estimated expenses for

this activity include two, one-week visits to these institutions to develop the curriculum.

Estimated total cost for this activity is $30,000.

3.1.7 **Y4-Y5: Provide Annual General Support to Institution to Implement Training, (e.g., Support for Faculty, Materials):** To sustain these institutional programmes over time, the HED will provide support to these institutions, such as lecture space, furniture, faculty support, materials, and other operational and technical support, as required. While these costs may change or vary depending on the results of the partnership, estimated costs are $25,000 per year, starting in Y4.

Estimated total cost for this activity is $50,000.

SO 3.2: Review and Update Human Resources for Health Policy to Include Health Promotion

3.2.1 **Y1-Y5: Update and Clarify HP Roles/Responsibilities, Terms of Service and Professional Development to Guide MOHS Leadership (Annually):** HED will meet with the HR office to clarify these roles, terms of services, etc., on a yearly basis.**There are no costs associated with this activity.**

3.2.2 **Y1-Y5: Advocate with MOHS Human Resources for Health and Partners to Influence Strengthening HED Workforce:** HED will meet with MOHS HRH and partners through existing forums such as the NGO forums, meetings with MOHS officials and individual meetings to strengthen the workforce. Examples include asks for additional staff, trainings, internships, mentorship programs, seconding staff, hiring consultants, and other areas for improvement, as required. This activity will be ongoing, starting in Y1 and continuing each year.

There are no costs associated with this activity.

OBJECTIVE 4: RAISE AWARENESS AND MOBILIZE RESOURCES FOR STRENGTHENED HEALTH PROMOTION

SO 4.1: Advocate for Increased Funding, Operational Support and Human Resources for Health Promotion Activities

4.1.1 **Y3: Develop Advocacy Plan to Identify Objectives, Key Audiences, Messages, and Opportunities to Raise the Profile of HP and Mobilize Resources:** With technical support from a partner organization (or consultant), a resource mobilization plan will be developed that identifies regular available resources and gaps for strengthened health promotion. It is recommended that the technical advisor (referenced in the inception phase) is already onboard for this activity. This activity will include the following:

- Y3: Conduct a resource mobilization workshop to identify public and private target audiences, opportunities and messages to raise visibility of the health promotion/HED and secure sustainable funding. This will explore businesses, donors and others already contributing to health promotion and those who aren't but are promising, along with key influencers. Results will form the foundation of a resource mobilization plan. Estimated costs for a 3-day advocacy workshop, which include venue, materials, printing, travel from the districts, etc., are $10,000.
- Y3: Develop an advocacy workplan based on the workshop. The plan will include target audiences for advocacy (including names of specific decision-makers), messages, opportunities, etc. This includes a consultant to support the plan development for an estimated $1,000 ($250/day for four days).
- Y3: National and district staff and partners will be oriented on the plan through existing meetings and through listservs, the HED Knowledge Gateway, NGO forums, pillar meetings, and other existing mechanisms.

Estimated total cost for this activity is $11,000.

4.1.2 **Y2-Y5: Develop and Distribute Evidence Briefs on Impact and Importance of HP in Sierra Leone:** The HED will require all partners working in health promotion to develop and share evidence briefs on their health promotion activities that show the impact of health promotion on health outcomes. Over time, a package of materials will highlight global, national, and, wherever possible, district data to inform conversations with political leaders and other decision makers about the benefits of health promotion. Briefs that highlight the benefits of health on businesses and the economy will also be developed and distributed. Estimated costs include:

- Y2-Y5: With technical support from a partner, the HED will develop and disseminate an evidence brief template through existing forums (NGO

forums, SM & Communication pillars, etc.), requesting partners to fill them out for all health promotion projects, to show impact of activities. HED will consider making this a requirement through the SLA process. This will be disseminated to partners yearly and provided to all new projects starting up in Sierra Leone.

- Y3 & Y5: HED will hire a consultant to compile evidence and develop a health promotion evidence packet that can be used for advocacy. The consultant will augment local data with global evidence while also linking health promotion to other development goals and outcomes (e.g., economy, business). Consultant will be hired to gather data, write and format the information into a packet of evidence briefs. Costs for this consultant are estimated at $5,000 ($2,500 x 2 [Y3 & Y5]).
- Y3 & Y5: HED will disseminate the briefs through a launch (below) and through existing mechanisms (e.g., Knowledge Gateway, listservs, NGO forums, etc.), encouraging partners to use them to advocate for more resources for health promotion. This involves developing a PPT to use in these forums. Dissemination will occur in Y3 and Y5. Estimated costs include $500 for printing ($250 x 2 [Y3 & Y5]).

Estimated total cost for this activity is $5,500.

4.1.3 **Y4: Hold Training for Journalists to Orient Press on Covering Health Promotion Stories:** With technical support from partners (e.g., BBC Media, CDC), a 2-day training programme designed to teach and motivate journalists to cover health promotion stories more accurately will be held. As part of the training, the MOHS can announce a contest for the best story on health promotion covered during the year. Estimated costs for this event will include travel expenses for approximately 30 journalists and workshop expenses such as venue, materials and meals and an award for the best journalist (e.g., mobile phone), to be awarded later in the year, totaling approximately $16,000.

Estimated total cost for this activity is $16,000.

4.1.4 **Y4: Hold National Media Event to Launch Evidence Briefs and Raise Visibility of Health Promotion:** This event will involve the following:

- Develop invitation list with public and private decision-makers, donors, media and partner organizations, then develop and send invitations. These are no costs for this activity.
- Develop and distribute press release about the evidence briefs. These are no costs for this activity.
- Hold media/launch event distribute evidence briefs. Estimated costs are $7,500 (venue with lunch for up to 50 people, photographers, small token awards [e.g., desk item, plaque]). Activity involves these actions:
    - Recruit high-level health promotion champions within donor

organizations, the government, and businesses to speak about health promotion benefits, asking participants to invest in HP.
- Present awards to government officials and businesses that have invested or contributed to HP in a promising way.

Estimated total cost for this activity is $7,500.

4.1.5 **Y5: Orient District-level Decision-makers (e.g., District Council, VDCs, FMCs/HMCs) on Impact of HP via Advocacy "Road Shows":** Similar to the launch above, smaller-scale advocacy "road shows" will highlight the benefits of health promotion in each of the 14 districts, with a presentation of the evidence package to district decision-makers (e.g., District Council member[s], Member of Parliament, etc.). Community radio, media, health provider staff, CHWS, etc., will be invited to attend, and awards will be given to champions and health promoters. This event could be combined with national campaign roll out activities (see Objective 2). Estimated costs for road shows include banners, printing, refreshments, awards, venue, and incentives for approx. $1,430 per district for a total cost of $20,000 for all 14 districts.

Estimated total cost for this activity is $20,000.

4.1.6 **Y5: Hold Advocacy Meeting with Parliamentary Health Committee to Showcase HP Successes and Advocate for Increased Funding for Health Promotion:** The HED with influential stakeholders will organize a committee room meeting in the House of Parliament and meet with the Parliamentary Health Committee and other key stakeholders such as the Minister of Finance and Economic Development, Minister of Health and Sanitation, CMO, and others to advocate for increased resources for health promotion, using evidence to demonstrate cost-effectiveness. Talking points should include clear asks for funding with a clear rationale for the funding (e.g., based on the advocacy plan) and include how health affects development issues (e.g., all of the SDGs).

There are no costs associated with this activity.

SO 4.2: Engage at Least Five New Private Sector Institutions to Invest in National Health Promotion Activities

4.2.1 **Y3: Develop Private Sector Brochure Outlining Options for Investing in HP in Sierra Leone, with a Business Case for Investing in HP**: This activity will require the following:

- With technical support from a partner organization (or consultant), meet with MOHS programme stakeholders and develop a list of HP investment options and potential benefits with costs. For example, investment options might include radio or TV spots or billboards promoting optional behaviors related to adolescent health, with estimated prices and

benefits, such as including the company logo and acknowledgement on the ad, etc. Estimated costs include consultant fee at $500/day for four days for a total of $2,000.

- Pay a consultant to develop a brochure, which includes the options, benefits and estimated costs described above along with a short business case outlining the business and economic value of investing in health in a presentable package. Estimated costs include consultant fees of $500/day for five days for a total of $2,500.
- Print the brochure. Estimated costs for printing is $500.

Estimated total cost for this activity is $5,000.

4.2.2 **Y3-Y5: Hold Annual Business Networking Forums to Encourage Investments in Health Promotion**: With both public and private sector partners, the MOHS will hold a networking forum each year to recognize business investing in health promotion and encourage others to invest. These are opportunities to showcase private sector contributions that have occurred in the past (e.g., during EVD), and to identify actions they can take through the *Investing in Health: A Private Sector Playbook.* Media will be invited to cover the events. Estimated costs for these forums include:

- Y3-Y5: Develop an agenda for the forums, an invitation list of public and private sector partners and send official letters of invitation. There are no costs associated with this activity.
- Y3-Y5: Recruit media to cover the event, and ask businesses to talk about the benefits of a healthy workforce and population. Estimated costs of $100 to cover photographer and media to attend and cover event for Y3.
- Y3-Y5: Facilitate forums with approximately 50 people in Y3, approximately 15 people in Y4 and Y5. Estimated costs are $10,000 for Y3, $6,000 for Y4 and Y5 (it is estimated that some private sector partners can cover some of these costs).
- Printing the agenda, brochure, other materials as needed. Estimated costs are about $300 per event for a total of $1,000 the three events.
- Developing and distributing a press release. There are no costs associated with this activity.

Estimated total cost for this activity is $23,100.

OBJECTIVE 5: IMPROVE MONITORING AND EVALUATION SYSTEMS FOR HEALTH PROMOTION

5.1.1 **Q4, Y1: Hold Stakeholder Meeting to Agree on HP Monitoring Indicators, and M&E Priorities for HP:** A stakeholder meeting with the DPPI and partners (e.g., M&E staff within partner organizations) will be held to agree on priorities for health promotion M&E. Specifically, the objectives will be to strengthen indicators for health promotion, and ensure they are aligned with overall national health indicators. See attached **Annex B** of the Strategy for a description of methods, indicators and targets for the Strategy and a sample of health promotion's impact on key public health indicators to be used in the discussion. Estimated costs for this activity include refreshments for stakeholder meeting.

Estimated total cost for this activity is $500.

5.1.2 **Y2-Y5: Create an M&E subcommittee with a TOR within the SM Pillar, and Facilitate the Incorporation of M&E in the Implementation of All Health Promotion Activities:** An M&E subcommittee will be developed within the SM Pillar to discuss a broad array of health promotion M&E topic areas, including discussions on indicators. This subcommittee will link with ongoing conversations within the M&E technical working group involved CHW health promotion. Estimated costs for this activity include refreshments for quarterly meetings at $500 per meeting totaling $2,000 per year starting in Y2.

Estimated total cost for this activity is $8,000.

5.1.3 **Y1 (Q3), Y2-Y5: Identify an HP Staff Person to Focus on M&E and Represent HED in M&E Steering Committee Meetings:** This activity will involve the following steps:

- Q4, Y1: HED will hire or reach out to other partners, such as the UNFP, for a dedicated M&E support person with an annual salary of approximately $22,000 per year. This HED staff person will focus on M&E and represent HED in M&E technical working group meetings.
- Y2-Y5: With partners in the M&E TWG's HP subgroup, these M&E staff and support will be responsible for the following:
    - developing standards guides for M&E
    - creating monitoring tools and collecting information to report on indicators
    - developing a training plan on new M&E framework

Ultimately there will be a sustainable, supported and structured monitoring

system in place to collect data on the health promotion indicators.

Estimated total costs for one M&E staff person at $22,000 per year, from Y1 (Q4) to Y5 is $93,500.

5.1.3 **Y1 (Q3), Y2-Y5: Develop M&E Framework with DPPI and Partner Support:** This activity will involve the following steps:

- Q3, Y1: Meeting with DPPI to have them second an M&E officer to the HED, which the DPPI will train.
- Q3-Q4, Y1: HED will reach out to other partners, such as the UNFP, for M&E support.
- Q3, Y1: HED to dedicate an HP staff person to focus on M&E and represent HED in M&E technical working group meetings.
- Y2-Y5: With partners in the M&E TWG's HP subgroup, these M&E staff and support will be responsible for the following:
    - developing standards guides for M&E
    - creating monitoring tools and collecting information to report on indicators
    - developing a training plan on new M&E framework

Ultimately there will be a sustainable, supported and structured monitoring system in place to collect data on the health promotion indicators.

There are no costs associated with this activity.

5.1.4 **Y2-Y5: Review and Incorporate Behavioral Indicators into Existing Monitoring Systems (e.g., HMIS):** An M&E staff person will meet with the DPPI to complete forms for adding approved indicators to the monitoring system. This will involve ongoing meetings within the M&E steering committee.

There are no costs associated with this activity.

5.1.5 **Y2-Y5: Ensure HP M&E Framework is Included in MOHS M&E Trainings to Districts:** HED will meet with the DPPI to ensure that the HED M&E framework is integrated into DPPI trainings.

There are no costs associated with this activity.

OBJECTIVE 6: STRENGTHEN KNOWLEDGE SHARING AND MANAGEMENT

6.1.1 **Q1, Y1: Develop a Knowledge Management Plan Based on 2016 Knowledge Management Assessment:**HC3's project will provide support to the HED on developing a knowledge management (KM) plan based on the assessment that was developed and shared in 2016. This plan will provide guidance to the dedicated HED staff on maintaining the KM system.

There are no costs associated with this activity.

6.1.2 **Q2, Q3, Y1, Y2-Y5: Provide Technical Assistance to Districts to Implement Knowledge Management Plan**: Technical assistance will be provided to district-level staff on the benefits of the KM system and using and maintaining it. JHUCCP's HC3 project will provide support to the HED in developing an orientation in Q2, Y1, which can be rolled out yearly from in Y2-Y5 to provide ongoing support. Estimated costs for this activity include travel expenses to the districts totaling approximately $2,000 per year (approx. $150 per district).

Estimated total cost for this activity is $10,000.

6.1.3 **Y1-Y5: Ensure HED and District SM Coordinators Have Internet Connectivity and an IT Person at the National Level:** It will be impossible for the HED and social mobilization coordinators to use the HED KM system—Knowledge Gateway—to share tools, messaging guides, resources, best practices and more without internet access. Estimated costs for this activity include a monthly subscription to an internet service and a modem plus installation and IT support, which amount to approximately $4,000 per quarter for a total of $20,000 per year in Y1 for the national system at HED headquarters and approximately $20,000 for modems for coordinators in the 14 districts, for a total of $40,000 per year starting in Y2.

Estimated total cost for this activity is $180,000.

6.1.4 **Y1-Y5: Organize Electronic Files at HED (Maintaining the Knowledge Gateway):** Through dedicated HED staff, electronic files will be maintained and organized in the HED Knowledge Gateway.

There are no costs associated with this activity.

6.1.5 **Q1, Y1: Organize Hardcopy Files at HED (Completing Filing System):** In 2016, under the HC3 project, a system was put in place to organize hardcopy files within HED headquarters, and this filing system will be finalized in 2017.

There are no costs associated with this activity.

6.1.6 **Q1, Y1: Create Tailored Email Listservs that Include Relevant Partners:** Listservs involving relevant partners will be developed and used. This email listserv will be linked with the Knowledge Gateway. The listserv will allow the HED and partners to share best practices, tools, and all health promotion resources and information.

There are no costs associated with this activity.

6.1.7 **Y2-Y5: Create Electronic and Hardcopy Versions of Health Promotion Newsletter Quarterly for Nationwide Distribution:** The HED will develop and disseminate electronic and hardcopy versions of an HED health promotion newsletter to inform a variety of stakeholders of updated health promotion news and events. Print copies will be distributed to district-level staff and electronic versions will be distributed to a broader set of stakeholders includes government decision-makers, partners, community stakeholders, and others. Copies of the newsletter will be available on the Knowledge Gateway. Possible steps involved in producing and distributing the newsletter include developing a newsletter template (e.g., in Word), agreeing on story ideas for each issue—which partners can contribute to—and writing stories and including photos. The HED will ask partners to contribute stories and photos to the newsletter. Estimated costs are for printing and are $1,000 per year starting in Y2.

Estimated total cost for this activity is $4,000.

6.1.8 **Q3, Y1: Ensure HED Page is on MOHS Website, Linking to Knowledge Gateway:** The HED will meet with the Ministry in charge of the MOHS website to ensure that an HED webpage is included on the site, with a link to the HED Knowledge Gateway.

There are no costs associated with this activity.

6.1.9 **Y2-Y5: Hold Annual HP Strategy Review and Best Practices Exchange Forum:** With technical support from partners, the HED will hold an annual National Health Promotion review meeting, where the government and partners will also present on best practices. Progress on the National Health Promotion Strategy will be reviewed with an account of where additional support is needed. Partners can share stories on health promotion approaches that work (and those that do not), and can share tools, evidence and resources useful to the group. This will be framed as a review as well as a learning opportunity. Partners will either be assigned or can volunteer to present. Estimated costs for this activity is $3,500 per year, which includes venue, materials, printing, and local travel expenses for representatives from the districts.

Estimated total cost for this activity is $14,000.

APPENDIX E. NATIONAL HEALTH PROMOTION STRATEGY (2017-2021) IMPLEMENTATION PLAN

		Year 1				Year 2	Year 3	Year 4	Year 5
		Q1	Q2	Q3	Q4				
IMPLEMENTATION PHASE									
0.1	Launch the Health Promotion Strategy								
0.2	Orient District Teams on the Health Promotion Strategy								
0.3	Meet with at Least 10 Partners/Donors to Secure Commitments to Support Individual Activities								
0.4	Develop Detailed TOR for Proposed Technical Advisor								
0.5	Recruit Technical Advisor to Support the HED								
	Subtotal								
	Inception Phase Total								
OBJECTIVE 1: STRENGTHEN HEALTH PROMOTION STRUCTURES									
SO 1.1: Rejuvenate the Social Mobilization and Communication Pillars at National Level and Strengthen Coordination Mechanisms									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
1.1.1	Review, Update and Disseminate SM Pillar TOR								
1.1.2	Support the Finalization and Dissemination of the Communications Pillar TOR								
1.1.3	Hold Monthly (More as Necessary) National SM Pillar Meetings								
1.1.4	Hold National Communications Pillar Meetings (PHNEOC) Every Two Weeks								
1.1.5	Participate in Inter-Pillar Meetings at National Level Called by PHNEOC for Improved Coordination								
1.1.6	Conduct Periodic Capacity Assessment for Strengthening								

	National SM Pillar and Provide Support								
SO 1.2: Rejuvenate the Social Mobilization Pillar at District Level and Strengthen Coordination Mechanisms									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
1.2.1	Review, Update and Disseminate District Level SM Pillar TOR								
1.2.2	Map Active SM Pillar Partners and Identify Dormant SM Pillars								
1.2.3	Hold a Revitalization Meeting to Present Mapping Landscape with Recommendations, TOR and Roles/Responsibilities								
1.2.4	Conduct Two-day Capacity Assessment Meetings and Support (e.g., Training) for all District SM Pillars								
1.2.5	Hold Monthly District-level SM Pillar Meetings (More Frequently as Needed) and Circulate Meeting Minutes								
1.2.6	Attend Monthly District Coordination Meetings in person and include HP on the agenda, while serving as health advocates								
1.2.7	Map and Develop MOUs with Functional Community Radio Stations in Each District for Message Dissemination								
SO 1.3: Strengthen Community-level Actors and Foster Community Ownership of Health									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
1.3.1	Develop and Disseminate Guidance on HP Roles and Responsibilities for Community Structures (e.g., VDCs, HMCs/FMCs, CHWs, Community Groups, etc.)								
1.3.2	Support Integrated Training on HP Roles/Responsibilities for VDCs/HMCs/FMCs and Community Structures								
OBJECTIVE 2: STRENGTHEN NATIONAL HEALTH PROMOTION INTERVENTIONS									

SO 2.1	Disseminate and Provide Guidelines on Use of Health Promotion Models								
		Year 1				Year 2	Year 3	Year 4	Year 5
		Q1	Q2	Q3	Q4				
2.1.1	Develop and Disseminate HP Model/Pathway Brochure and Orient Partners on HP Model/Pathway and Other Guidance through Standing Pillar Meetings								
2.1.2	Hold Regular MOHS Stakeholders Meetings to Include a Mandate in the SLA for Partners to Base Programming on Approved HP Model/Pathway, and Other Guidance Documents (e.g., SM TOR)								
SO 2.2: Support National Integrated Efforts to Reach Adolescents with Health Promotion									
		Year 1				Year 2	Year 3	Year 4	Year 5
		Q1	Q2	Q3	Q4				
2.2.1	Gather and Share Existing Evidence with National and District Partners on Adolescent Health Behaviors through HED Knowledge Gateway								
2.2.2	Conduct Biannual Meetings between HED and the School Health Program/Secretariat of Teenage Pregnancy to Strengthen Collaboration								
2.2.3	Support Adolescent Campaign Design and Implementation								
2.2.4	Support Advocacy on the Need to Reach Adolescents (e.g., Religious and Community Leaders)								
2.2.5	Facilitate Community-level Adolescent-focused Program Activities								
SO 2.3: Strengthen Community-level Actors in Health Promotion									
		Year 1				Year 2	Year 3	Year 4	Year 5
		Q1	Q2	Q3	Q4				
2.3.1	Conduct Mapping of Materials/Job Aids for Community-								

	level Actors and Supporting Partners to Identify Gaps								
2.3.2	Develop Health Promotion Materials/Job Aids for Community-level Actors Based on Mapping/Review								
2.3.3	Provide Opportunities (Training) for Community-level Actors to Use Health Promotion Materials and Become Health Promotion Advocates								
2.3.4	Conduct Mapping of Materials/Job Aids for In-service Healthcare Workers to Identify Gaps								
2.3.5	Develop Health Promotion Materials/Job Aids for Interpersonal Communication Skills for In-service Healthcare Workers								
2.3.6	Provide Training for In-service Healthcare Workers on Interpersonal Communication Skills and Using Job Aids/Materials and Provide Follow-up Support (Incentives, Mentoring, Supportive Supervision)								
SO 2.4: Establish Evidence-base on Behaviours and Communication Channels to Guide Programming									
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
2.4.1	Conduct Desktop Analysis to Identify Evidence Gaps on Knowledge, Attitudes, Practices and Behaviors Related to Priority Health Areas and Audiences								
2.4.2	Support the Design, Implementation and Dissemination of Studies to Fill Gaps in Evidence (See 2.4.1)								
2.4.3	Orient Government Agencies and Partners on Using Evidence in SBCC Programming								
2.4.4	Facilitate National Communication Channels Assessment to Map Existing Approaches and Effectiveness, Selecting Key Channels/Approaches (e.g., Radio, Mobile, TV, Community Engagement)								
2.4.5	Based on Assessment, Invest in Select Communication								

	Channels for Health Promotion (See 2.4.4)								
SO 2.5	**Develop and Launch a National Health Promotion Campaign**								
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
2.5.1	Develop a National Health Promotion Campaign that Includes a National Logo								
2.5.2	Hold National- and District-level Campaign Launches								
2.5.3	Roll Out National Campaign (e.g., Broadcast, Print Distribution)								
2.5.4	Monitor and Evaluate National Campaign Outcomes								
SO 2.6	**Facilitate Development of an Emergency Communication Plan**								
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
2.6.1	Contribute to Emergency Communication Plan and Training Curriculum								
2.6.2	Support Emergency Communication Training at District-level								
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
SO 2.7	**Strengthen Integration of Health Promotion Activities with Activities in Other Sectors – e.g., Education, Agriculture, Youth – to Achieve Health and Development Gains**								
2.7.1	Convene Multi-stakeholder Meetings with Relevant Ministries to Integrate Health Promotion								
2.7.2	Assign HP Role (e.g., Seconded, Focal Point) to Support HP Activities in Four Ministries (e.g., Education, Agriculture, Youth, Gender)								

SO 2.8	Launch in Full Effect a National Public Health Information Line								
		Year 1				Year 2	Year 3	Year 4	Year 5
		Q1	Q2	Q3	Q4				
2.8.1	Conduct Resource Mobilization Activities and Secure Funding from Stakeholders								
2.8.2	Set-up a Toll-free Hotline Number or Operationalize/Broaden the Scope of the Existing Ministry of Health's 117 Call Centre Line								
2.8.3	Conduct Activities to Educate the Public on Using the Public Health Line								
2.8.4	Integrate the Call Centre Approach to Health Promotion in all MOHS Strategic Plans as Part of Strengthening a Continuous National level Method of Health Promotion								
2.8.5	Conduct Trainings for Call Centre Health Promotion and Information with Staff								
	OBJECTIVE 3: IMPROVE HUMAN RESOURCES AND CAPACITY STRENGTHENING FOR HEALTH PROMOTION								
SO 3.1	**Develop Training Program for Pre-service and In-service Health Promotion Professionals**								
		Year 1				Year 2	Year 3	Year 4	Year 5
		Q1	Q2	Q3	Q4				
3.1.1	Develop National Training Plan of In-service Training Opportunities for HP Professionals								
3.1.2	Assign HED Staff to Attend International Health Conference (e.g., ASTMH, SBCC Conference) and Health Communication Study Tour (e.g., WHO)								
3.1.3	Hold At Least One HP-focused Capacity Building TOT Per Year for HED and Partners at National/District Level (e.g., DSMCs) – As Per Training Plan								

3.1.4	Hold a Strategic Health Communication Training in Sierra Leone (Repeated Every Three Years) – As Per Training Plan								
3.1.5	For Pre-service Training, Assess and Finalize Potential Partnership with Training Institution(s)								
3.1.6	Develop Curriculum with Selected Training Institution(s)								
3.1.7	Provide Annual General Support to Institution to Implement Training, (e.g., Support for Faculty, Materials)								
SO 3.2	**Review and Update Human Resources for Health Policy to Include Health Promotion**								
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
3.2.1	Update and Clarify HP Roles/Responsibilities, Terms of Service and Professional Development to Guide MOHS Leadership (Annually)								
3.2.2	Advocate with MOHS Human Resources for Health and Partners to Influence Strengthening HED Workforce								
	OBJECTIVE 4: RAISE AWARENESS AND MOBILIZE RESOURCES FOR STRENGTHENED HEALTH PROMOTION								
SO 4.1	**Advocate for Increased Funding, Operational Support and Human Resources for Health Promotion Activities**								
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
4.1.1	Develop Advocacy Plan to Identify Objectives, Key Audiences, Messages and Opportunities to Raise the Profile of HP and Mobilize Resources								
4.1.2	Develop and Disseminate Evidence Briefs on Impact and Importance of HP in Sierra Leone								
4.1.3	Hold Training for Journalists to Orient Press on Covering Health Promotion Stories								

4.1.4	Hold National Media Event to Launch Evidence Briefs and Raise Visibility of Health Promotion								
4.1.5	Orient District-level Decision-makers (e.g., District Council, VDCs, FMCs/HMCs) on Impact of HP via Advocacy "Road Shows"								
4.1.6	Hold Advocacy Meeting with Parliamentary Health Committee to Showcase HP Successes and Advocate for Increased Funding for Health Promotion								
SO 4.2	**Engage at Least Five New Private Sector Institutions to Invest in National Health Promotion Activities**								
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
4.2.1	Develop Private Sector Brochure Outlining Options for Investing in HP in Sierra Leone, with a Business Case for Investing in HP								
4.2.2	Hold Annual Business Networking Forums to Encourage Investments in Health Promotion								
	OBJECTIVE 5: IMPROVE MONITORING AND EVALUATION SYSTEMS FOR HEALTH PROMOTION								
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
5.1.1	Hold Stakeholder Meeting to Agree on HP Monitoring Indicators and M&E Priorities for HP								
5.1.2	Create M&E Subcommittee with a TOR within the SM Pillar, and Facilitate the Incorporation of M&E in the Implementation of All Health Promotion Activities								
5.1.3	Identify an HP Staff Person to Focus on M&E and Represent HED in M&E Steering Committee Meetings								
5.1.4	Develop M&E Framework with DPPI and Partner Support								
5.1.5	Review and Incorporate Behavioral Indicators into								

	Existing Monitoring Systems (e.g., HMIS)								
5.1.6	Ensure HP M&E Framework is Included in MOHS M&E Trainings to Districts								
	OBJECTIVE 6: STRENGTHEN KNOWLEDGE SHARING AND MANAGEMENT								
		Year 1				**Year 2**	**Year 3**	**Year 4**	**Year 5**
		Q1	**Q2**	**Q3**	**Q4**				
6.1.1	Develop a Knowledge Management Plan Based on 2016 Knowledge Management Assessment								
6.1.2	Provide Technical Assistance to Districts to Implement Knowledge Management Plan								
6.1.3	Ensure HED and District SM Coordinators Have Internet Connectivity and IT person at the National Level								
6.1.4	Organize Electronic Files at HED (Maintaining the Knowledge Gateway)								
6.1.5	Organize Hardcopy Files at HED (Completing Filing System)								
6.1.6	Create Tailored Email Listservs that Include Relevant Partners								
6.1.7	Create Electronic and Hardcopy Versions of Health Promotion Newsletter Quarterly for Nationwide Distribution								
6.1.8	Ensure HED Page is on MOHS Website, Linking to Knowledge Gateway								
6.1.9	Hold Best Practices Exchange Semi-annually through SM Pillar Meeting								

APPENDIX G. M&E INDICATORS FOR NATIONAL HEALTH PROMOTION STRATEGY (2017-2021)

Monitoring & Evaluation		Illustrative Indicators	Source of Data	Measurement
INCEPTION PHASE				
0.1	Launch the Health Promotion Strategy	HP Strategy launched	Program reports	
0.2	Orient District Teams on the Health Promotion Strategy	Orientations to all district teams held	Program reports	
0.3	Meet with at Least 10 Partners / Donors to Secure Commitments to Support Individual Activities	Meetings with at least 10 key partners and/or donors held	Program reports	
0.4	Develop Detailed TOR for Proposed Technical Advisor	TOR developed	Program reports	
0.5	Recruit Technical Advisor to Support the HED	Technical advisor assigned	Program reports	
OBJECTIVE 1: STRENGTHEN HEALTH PROMOTION STRUCTURES				
SO 1.1: Rejuvenate the Social Mobilization and Communication Pillars at National level and Strengthen Coordination Mechanisms				
1.1.1	Review, Update and Disseminate SM Pillar TOR	SM Pillar TOR disseminated	Program reports	
1.1.2	Support the Finalization and Dissemination of the Communications Pillar TOR	Communication Pillar TOR disseminated	Program reports	
1.1.3	Hold Monthly (more as necessary) National SM Pillar Meetings	Monthly SM Pillar meetings held	Program reports	
1.1.4	Hold National Communications Pillar Meetings (PHNEOC) Every Two Weeks	Periodic Communication Pillar Meetings held	Program reports	
1.1.5	Participate in Inter-Pillar Meetings at National Level Called by PHNEOC for Improved Coordination	HED representation in meetings	Program reports	

Monitoring & Evaluation		Illustrative Indicators	Source of Data	Measurement
1.1.6	Conduct Capacity Assessment for Strengthening National SM Pillar and Provide Support	Two capacity assessments completed and support provided	Program reports	
SO 1.2:Rejuvenate the Social Mobilization pillar at District Level and Strengthen Coordination Mechanisms				
1.2.1	Review, Update and Disseminate District Level SM Pillar TOR	District-level TOR disseminated	Program reports	
1.2.2	Map Active SM Pillar Partners and Identify Dormant SM Pillars	Mapping completed	Program reports	
1.2.3	Hold a Revitalization Meeting to Present Mapping Landscape with Recommendations, TOR and Roles/Responsibilities	Revitalization meeting held	Program reports	
1.2.4	Conduct Two-day Capacity Assessment Meetings and Support (e.g., Training) for all District SM Pillars	Capacity building assessment conducted in a 14 districts	Program reports	
1.2.5	Hold Monthly District-level SM Pillar Meetings (more frequently as needed), and Circulate Meeting Minutes	District-level SM Pillar meetings held	Program reports	
1.2.5	Participate in Monthly District Coordination Meetings	HED representation in meetings documented	Program reports	
1.2.7	Map and Develop MOUs with Functional Community Radio Stations in each District for Message Dissemination	MOUs with community radio stations developed	Program reports	
S.O. 1.3: Strengthen Community-level Actors and Foster Community Ownership of Health				
1.3.1	Develop and Disseminate Guidance on HP Roles and Responsibilities for Community Structures (e.g., VDCs, HMCs/FMCs, CHWs, Community Groups, etc.)	Community roles/responsibilities guidance disseminated	Program reports	
1.3.2	Support Integrated Training on HP Roles/Responsibilities for VDCs/HMCs/FMCs	Training completed	Program	

Monitoring & Evaluation		Illustrative Indicators	Source of Data	Measurement
	and Community Structures		reports	
OBJECTIVE 2: STRENGTHEN NATIONAL HEALTH PROMOTION INTERVENTION				
SO 2.1: Disseminate and Provide Guidelines on Use of HP Models				
2.1.1	Develop and Disseminate HP Model/Pathway Brochure and Orient Partners on HP Model/Pathway and other Guidance through Standing Pillar Meetings	Brochure disseminated	Program reports	
2.1.2	Hold Regular MOHS Stakeholders Meetings to Include a Mandate in the SLA for Partners to Base Programming on Approved HP Model/Pathway, and Other Guidance Documents (e.g., SM TOR)	Meeting held	Program reports	
SO 2.2: Support National Integrated Efforts to Reach Adolescents with Health Promotion				
2.2.1	Gather and Share Existing Evidence with National and District Partners on Adolescent Health Behaviors through HED Knowledge Gateway	Evidence shared	Program reports	
2.2.2	Conduct Bi-annual Meetings between HED and the School Health Program / Secretariat of Teenage Pregnancy to Strengthen Collaboration	Meetings held	Program reports	
2.2.3	Support Adolescent Campaign Design and Implementation	Adolescent campaign implemented	Program reports	
2.2.4	Support Advocacy on the Need to Reach Adolescents (e.g., Religious & Community Leaders)	Advocacy events held	Program reports	
2.2.5	Facilitate Community-level Adolescent-focused Program Activities	District events held	Program reports	
SO 2.3: Strengthen Community-level Actors in Health Promotion				
2.3.1	Conduct Mapping of Materials/Job Aids for Community-level Actors and Supporting Partners to Identify Gaps	Mapping completed	Program reports	
2.3.2	Develop Health Promotion Materials/Job Aids for Community-level actors Based on Mapping/Review	Tools and resources developed	Program reports	
2.3.3	Provide Opportunities (Training) for Community-level Actors to Use Health Promotion Materials and Become Health Promotion Advocates	Training conducted	Program reports	
2.3.4	Conduct Mapping of Materials/Job Aids for In-service Healthcare Workers to	Mapping completed	Program	

Monitoring & Evaluation		Illustrative Indicators	Source of Data	Measurement
	Identify Gaps		reports	
2.3.5	Develop Health Promotion Materials/Job Aids for Interpersonal Communication Skills for In-service Healthcare Workers	Materials and job aids developed	Program reports	
2.3.6	Provide Training for In-service Healthcare Workers on Interpersonal Communication Skills and Using Job Aids/Materials and Provide Follow-up Support (Incentives, Mentoring, Supportive Supervision)	Training conducted	Program reports	
SO 2.4: Establish Evidence-base on Behaviors and Communication Channels to Guide Programming				
2.4.1	Conduct Desktop Analysis to Identify Evidence Gaps on Knowledge, Attitudes, Practices and Behaviors Related to Priority Health Areas and Audiences	Desktop analysis conducted	Program reports	
2.4.2	Support the Design, Implementation and Dissemination of Studies to Fill Gaps in Evidence (see 2.4.1)	Research conducted	Program reports	
2.4.3	Orient Government Agencies and Partners on Using Evidence in SBCC Programming	Orientation conducted	Program reports	
2.4.4	Facilitate National Communication Channels Assessment to Map Existing Approaches and Effectiveness, Selecting Key Channels/Approaches (e.g., Radio, Mobile, TV, Community Engagement)	Report on assessment completed	Program reports	
2.4.5	Based on Assessment, Invest in Select Communication Channels for Health Promotion (see 2.4.4)	Priority communication channels funded	Program reports	
SO 2.5: Develop and Launch a National Health Promotion Campaign				
2.5.1	Develop a National Health Promotion Campaign that Includes a National Logo	National health campaign developed	Program reports	
2.5.2	Hold National- and District-level Campaign Launches	Launches conducted	Program reports	
2.5.3	Roll Out National Campaign (e.g., Broadcast, Print Distribution)	Media aired, community events conducted	Program reports	
2.5.4	Monitor and Evaluate National Campaign Outcomes	Monitoring and evaluation reports	Program reports	

Monitoring & Evaluation		Illustrative Indicators	Source of Data	Measurement
		completed		
SO 2.6: Facilitate Development of Emergency Communication Plan				
2.6.1	Contribute to Emergency Communication Plan and Training Curriculum	Plan completed	Program reports	
2.6.2	Support Emergency Communication Training at District-level	Training conducted in each district	Program reports	
SO 2.7: Strengthen Integration of Health Promotion Activities with Activities in Other Sectors – e.g., Education, Agriculture, Youth – to Achieve Health and Development Gains				
2.7.1	Convene Multi-stakeholder Meetings with Relevant Ministries to Integrate Health Promotion	Meeting held annually	Program reports	
2.7.2	Assign HP Role (e.g., Seconded, Focal Point) to Support HP Activities in 4 Ministries (e.g., Education, Agriculture, Youth, Gender)	Point people assigned	Program reports	
SO 2.8 Launch in full effect a national public health information line				
2.8.1	Conduct Resource Mobilization Activities and Secure Funding from Stakeholders	Resource mobilization activities conducted	Program reports	
2.8.2	Set-up a Toll-free Hotline Number or Operationalize/Broaden the Scope of the Existing Ministry of Health's 117 Call Centre Line	Call centre line is set up	Program reports	
2.8.3	Conduct Activities to Educate the Public on Using the Public Health Line	Education activities conducted	Program reports	
2.8.4	Integrate the Call Centre Approach to Health Promotion in all MOHS Strategic Plans as Part of Strengthening a Continuous National level Method of Health Promotion	Center approach is integrated into MOHS strategic plans	Program reports	
2.8.5	Conduct Trainings for Call Centre Health Promotion and Information with Staff	Trainings conducted	Program reports	
OBJECTIVE 3: IMPROVE HUMAN RESOURCES AND CAPACITY STRENGTHENING FOR HEALTH PROMOTION				

Monitoring & Evaluation		Illustrative Indicators	Source of Data	Measurement
SO 3.1: Develop Training Program for Pre-service and In-service Health Promotion Professionals				
3.1.1	Develop National Training Plan of In-service Training Opportunities for HP Professionals	Plan completed	Program reports	
3.1.2	Assign HED Staff to Attend International Health Conference (e.g., ASTMH, SBCC Conference) and Health Communication Study Tour (e.g., WHO)	International health conference and study tour attended	Program reports	
3.1.3	Hold At Least One HP-focused Capacity Building TOT Per Year for HED and Partners at National/District Level (e.g., DSMCs)- As Per Training Plan	Annual training held at national/district level	Program reports	
3.1.4	Hold a Strategic Health Communication Training in Sierra Leone (Repeated Every Three Years) - As Per Training Plan	Training held	Program reports	
3.1.5	For Pre-service Training, Assess and Finalize Potential Partnership with Training Institution(s)	Assessment report completed	Program reports	
3.1.6	Develop Curriculum with Selected Training Institution(s)	Curriculum developed	Program reports	
3.1.7	Provide Annual General Support to Institution to Implement Training, (e.g., Support for Faculty, Materials)	Institutional training implemented	Program reports	
SO 3.2: Review and Update Human Resources for Health Policy to Include Health Promotion				
3.2.1	Update and Clarify HP Roles/Responsibilities, Terms of Service and Professional Development to Guide MOHS Leadership (Annually)	Health promotion scheme of service updated	Program reports	
3.2.2	Advocate with MOHS HRH and Partners to Influence Strengthening HED Workforce	Meetings with MOHS HRH/HSC held	Program reports	
OBJECTIVE 4: RAISE AWARENESS AND MOBILIZE RESOURCES FOR STRENGTHENED HEALTH PROMOTION				
SO 4.1: Advocate for Increased Funding, Operational Support and Human Resources for Health Promotion Activities				
4.1.1	Develop Advocacy Plan to Identify Objectives, Key Audiences, Messages, and	Advocacy plan	Program	

Monitoring & Evaluation		Illustrative Indicators	Source of Data	Measurement
	Opportunities to Raise the Profile of HP and Mobilize Resources	developed	reports	
4.1.2	Develop and Disseminate Evidence Briefs on Impact and Importance of HP in Sierra Leone	Briefs developed	Program reports	
4.1.3	Hold Training for Journalists to Orient Press on Covering Health Promotion Stories	Journalist training held	Program reports	
4.1.4	Hold National Media Event to Launch Evidence Briefs and Raise Visibility of Health Promotion	Launch held	Program reports	
4.1.5	Orient District-level Decision-makers (e.g., District Council, VDCs, FMCs/HMCs) on Impact of HP via Advocacy "Road Shows"	Orientation conducted	Program reports	
4.1.6	Hold Advocacy Meeting with Parliamentary Health Committee to Showcase HP Successes and Advocate for Increased Funding for Health Promotion	Event held	Program reports	
SO 4.2: Engage at Least Five New Private Sector Institutions to Invest in National Health Promotion Activities				
4.2.1	Develop Private Sector Brochure Outlining Options for Investing in HP in Sierra Leone, with a Business Case for Investing in HP	Brochure developed	Program reports	
4.2.2	Hold Annual Business Networking Forums to Encourage Investments in Health Promotion	Networking forums conducted	Program reports	
OBJECTIVE 5: IMPROVE MONITORING AND EVALUATION SYSTEMS FOR HEALTH PROMOTION				
5.1.1	Hold Stakeholder Meeting to Agree on HP Monitoring Indicators, and M&E Priorities for HP	Meeting held	Program reports	
5.1.2	Create M&E Subcommittee with a TOR within the SM Pillar, and Facilitate the Incorporation of M&E in the Implementation of All Health Promotion Activities	Subgroup active	Program reports	
5.1.3	Identify an HP Staff Person to Focus on M&E and Represent HED in M&E Steering Committee Meetings	Staff member appointed	Program reports	
5.1.4	Develop M&E Framework with DPPI and Partner Support	M&E framework completed	Program reports	
5.1.5	Review and Incorporate Behavioral Indicators into Existing Monitoring Systems (e.g., HMIS)	Behavioral indicators incorporated	Program reports	
5.1.6	Ensure HP M&E Framework is Included in MOHS M&E Trainings to Districts	Trainings conducted	Program reports	

Monitoring & Evaluation		Illustrative Indicators	Source of Data	Measurement
OBJECTIVE 6: STRENGTHEN KNOWLEDGE SHARING AND MANAGEMENT				
6.1.1	Develop a Knowledge Management Plan based on 2016 Knowledge Management Assessment	Plan documented	Program reports	
6.1.2	Provide Technical Assistance to Districts to Implement Knowledge Management Plan	TA provided to 14 district teams	Program reports	
6.1.3	Ensure HED and District SM Coordinators Have Internet Connectivity	Internet connectivity is enabled for HED and SM coordinators	Program reports	
6.1.4	Organize Electronic Files at HED (Maintaining the Knowledge Gateway)	Electronic files organized	Program reports	
6.1.5	Organize Hardcopy Files at HED (Completing Filing System)	Hardcopy files organized		
6.1.6	Create Tailored Email Listservs that Include Relevant Partners	Listservs developed and in use	Program reports	
6.1.7	Create Electronic and Hardcopy Versions of Health Promotion Newsletter for Nationwide Distribution	Electronic and Hardcopy Versions of the Newsletter produced and disseminated periodically	Program reports	
6.1.8	Ensure HED Page is on MOHS Website, Linking to Knowledge Gateway	HED webpage is on MOHS website, linking to Knowledge Gateway	Program reports	
6.1.9	Hold Best Practices Exchange Semi-annually Through SM Pillar Meeting	Community of practice meetings held semi-annually	Program reports	

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